THE BRISTOL INFIRMARY 1761-2 AND THE 'LABORIOUS-INDUSTRIOUS POOR'

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ABSTRACT

A study has been made of Bristol Infirmary in the year from Michaelmas 1761 to Michaelmas 1762. This has included exhaustive analysis of the In- and Out-patient Registers, as well as other Infirmary documents and publications. The central purpose of the work has been to examine how patients were treated, in general as well as therapeutically, and to relate the treatment to the power relationships bearing upon it.

The Infirmary is put into the context of civic history and affairs generally and is shown to have been a major feature of Bristol life. The purposes, both ostensible and fulfilled, of the Infirmary, are compared with and distinguished from those of the medical and surgical provisions of the poor law. The Infirmary accepted patients irrespective of provenance, but restricted its intake to those likely to benefit within three months. Moral improvement, although one purpose, was secondary to healing.

The Infirmary's treatment of patients was humane and, over a range of distempers, almost certainly therapeutically effective. Epidemiology, as shown by the Registers, indicates the seasonality of some of the more frequent distempers.

This work shows that a simplistic theory of self-interest is insufficient in itself to account for the public giving which made the Infirmary possible. The study also throws up the question of the effectiveness of government by amateurs. It is evident that the 18th century British voluntary hospitals differed among themselves in their relationships to the poor law, and in whether they admitted the acutely ill or chronically sick; the case is made for further work on a typology of early voluntary hospitals.

By concentrating on one year in one place, certain fallacies are avoided. This restriction of method has not, however, prevented light being shed on general matters.

The reliability of the documents consulted, especially the patient Registers, is investigated, fully discussed, and taken into consideration in drawing inferences.

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The Special Trustees of the United Bristol Hospitals made two grants of £500 each at an early stage of the work to pay University fees and minor expenses. I am happy to record my thanks to them.

DECLARATION

All the work reported in this thesis as having been carried out by me was completed by myself alone except as acknowledged. The views expressed are those of the author and not of the University.

Bernice Bass

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INTRODUCTION

Purpose and method

0.1 THE VOLUNTARY HOSPITAL

A hospital is a many-faced indicator of the condition of the society in which it is found. In it there meet economics and compassion, power and charity, knowledge and its application, money and the invaluable, while it brings into relationship poor with rich and learned with simple. Existing British hospitals, for the most part, have a double ancestry. Immediately before the inception of the National Health Service in 1948, about 70% of hospital beds were municipally provided and about 30% maintained by voluntary contributions.[1] (Private and commercially run hospitals and nursing homes were proportionately slight.)

The voluntary hospital is an institution arising in the British Isles in the 18th century, during which time the earth was becoming increasingly dominated by Europe, a Europe in which Great Britain was achieving ascendancy, with Bristol as Great Britain's second city and second port. The ideological characteristic of this mercantile civilisation, the use of human reason, was unlimited in its possibilities. Religious `enthusiasm' met with disapproval, although in some religious movements feeling more than held its own against thinking, contributing to England's denominational diversity, amply manifested in Bristol. This was a civilisation with enormous differences between the condition of the rich or comfortable and that of the numerous poor. A reaction to this economic and social division, and arising from the confidence engendered by wealth and a faith in reason, was the founding of the voluntary hospitals, of which the Westminster Hospital, founded in 1719, was the first.

Outside London and Edinburgh, where the Infirmary was founded in 1729, the first voluntary hospital was that of Winchester, opening in 1736. Earlier, in 1735, steps had been taken towards setting up the Bristol Infirmary, to which the first patient was admitted in 1737. However, the functionally important distinction among early voluntary hospitals is probably not whether they were in a capital city or in the provinces, but by which type of rules they were governed. This second distinction has been made apparent by the present research, and will be discussed in the concluding chapter of this thesis, where observations are made on the results of the investigation.

0.2 THE PURPOSE OF THE STUDY

The purpose of this study has been to explore the personal, social, historical and medical implications of the work of the Bristol Infirmary in the mid-18th century, when it had had a quarter-century (i.e. a single generation) to become established. (It will be seen in Chapter 1 that certain important changes in the Rules were made in those 25 years.)

The investigation has been carried out within two contraints. The first is that attention is centred on patients. For this reason there will be scant mention of individual physicians and surgeons, although methods and efficacy of treatment, impinging as they do on the patients, have been investigated and will be discussed.

The second constraint is that the study is concerned primarily with a single year, from Michaelmas 1761 to Michaelmas 1762. To this end a group of contemporary primary sources, of which the Admission Registers[2] are the most important, were examined and analysed in detail, as will be seen in Appendix 1.

This concentration of attention on a single year has three advantages, two statistical and one qualitative. Firstly, it enables one to use all the explicit and implicit

data in the registers, so obviating sampling errors. Secondly, there is no pooling of data from years that may be different with respect to a trend; such pooling can bring into single totals quantities which can imply false information by not being kept distinct. The qualitative advantage is this. If a single year is taken, and if it is asked of all documents not of that year whether they are relevant to it, and, if so, in what way, one may (as with the statistics) avoid applying to one period sources referring to another. This bears strongly on the 18th century, especially its second half, a time of rapid change when the agricultual revolution was being accompanied by the industrial revolution, itself then being transformed by the factory system.

A narrow concentration on one year may seem to limit the scope of what can be learnt. In the present study, however, the narrow focussing of enquiry leads to the consideration of matters of wider generality and raises and helps to elucidate matters usually associated with broader and less intensive research. Taking a time-slice for intensive study or pooling data from a span of years each has its advantages. No claim is made here that the former method is superior. Nevertheless, it has, as has been explained, its peculiar strengths. Furthermore, it appears not to have been used in studies of voluntary hospitals, and is offered here not only for its advantages in historical research, but also for any interest that there may be in the novelty of approach, with its possible advantages.

One purpose of this work is therefore to explore the possible fruitfulness of a new method and a new approach. Both have been justified by the answers it gives to, among other things, the following questions. If, during sickness, the Poor Law took care of the poor and money took care of the rich, why was there a need for a voluntary hospital at all and to what extent was 18th century hospital medicine of any use to anyone - patients, Subscribers or the medical profession? If the Infirmary was only an extension

of the Poor Law why was it founded? Was its only difference the mechanism of funding?

Naturally, a single year can be understood only within a wider context. To understand the findings concerning the year 1761-2, an investigation has been carried out into the circumstances of the Bristol Infirmary's founding, into its aims, expressed in word or in deed, and into its early development.

0.3 THE WORK OF OTHER WRITERS

Thus far some indications have been given of this work's purpose and method. By these it is not only characterised in itself but can also be defined in relation to the work of others. Such work, as it impinges upon this study, falls naturally into two categories, both of which can themselves be further sub-divided; firstly, hospital histories[3] and secondly, studies on the relationship between charity and medicine.

Histories encompassing a number of hospitals are more varied than individual hospital histories in their modes of presentation, and they may encompass, as well as hospitals, other social topics (see, for example, Roy Porter's *English Society in the Eighteenth Century* which, despite the generality of its title, incorporates specific discussion of hospitals.[4]) The commonest generalisation in the English-language literature on 18th century hospitals is that the beginning and increase of these hospitals constituted the `British Voluntary Hospital Movement'. The notion of a `Movement' is already used by, for example, Buer in 1926.[5] The work presented in this thesis, however, suggests that there were at least two distinct contemporary lines of hospitals,[6] each hospital modelling itself on an existing hospital in its own line. Although reliable generalisation on this point needs further work, the study itself suggests that it may be inimical to such enquiry if

too much stress is put on there being a single `Movement', useful as this concept may be for some purposes.

Among these histories dealing with or generalising from a number of hospitals, some are of limited relevance to the present study because, like those of Abel-Smith[7] or Webster,[8] they refer to a period later than 1761-2. Similarly, Foucault's *The Birth of the Clinic* is explicitly concerned with the late 18th century French hospitals and, much more, those of the 19th century.[9] Woodward has attempted to bring together the history of voluntary hospitals from 1720 to 1875,[10] but the scope of the enterprise, with compression into fewer than 200 pages, does not always permit a clear distinction of periods in the generalisations offered. Woodward overcomes this by working from specific examples but of these the same great scope and compression have forced excessive selectivity. Nevertheless the book is a valuable introduction, and the illustrative material relevant to the present study.

The work of Mary Fissell is of prime importance. Her paper,[11] which refers throughout to the 18th century in general (although using 1771-1805 for some statistical purposes), argues that `lack of local family resources shaped health-care provision',[12] and, more specifically, that `many infirmary patients did not have a local family, which suggests that the Infirmary played a role similar to that of the rural Poor Law in providing alternative domestic care'.[13] This last statement, in particular, will be revised in this work.

Fissells' study is more developed in her book,[14] which treats of attitudes to patients in the first hundred years of the Bristol Infirmary, 1736 to the early 19th century. In writing on the first half of this period, Fissell's case is that the Corporation of the Poor (formed in 1696 by union of the poor relief of the city parishes[15]) and the Infirmary had similar functions,[16] and that their primary purpose was moral reform, to which, in the

Infirmary, healing was secondary. On the first point, it needs to be asked why, since the Corporation of the Poor provided medical services, In-patient care and home visiting, the Infirmary was founded at all. In fact the Subscribers of the Infirmary, who included some people with power in the Corporation of the Poor, set out explicitly to provide for patients of a sort not eligible for poor relief, (Porter makes the point that the infirmaries were typically not meant for paupers.[17]) It will be shown in Chapter 1 that difference of purpose could entail conflict between the Corporation of the Poor and the Infirmary.

Fissell quotes Alured Clarke, the founder of Winchester County Hospital in 1736, that patients should be kept in hospital `for so long a time as is necessary to beget contrary habits',[18] and lets the reader assume that Clarke's words applied to Bristol also. Fissell makes assumptions about equivalence of objects and practices between Winchester and Bristol which, again, will be revised in this work. Westminster Hospital, not Winchester, will be shown to be the blueprint for Bristol, which thus was founded on quite different principles.

On the second point, that the primary purpose of the Infirmary was moral reform, Fissell refers to `the moral reformers' program of incarceration'.[19] It will be shown that, in 1761-2, Bristol Infirmary In-patients had a median stay of about 5 weeks, and were limited to 13 weeks,[20] could take their own discharge,[21] and could be thrown out for disruptive behaviour.[22] However, to bring about the moral reform of adult Bristolians in 5 (or even 13) weeks would have been an achievement which would surely still be celebrated in the annals of education. One of the purposes of the thesis is to examine this contention - were patients `incarcerated' until their behaviour improved and what note was taken of their `moral reform' on discharge? Were the sermons preached dedicated to the reform of the patients' attitudes and mores? These are issues which will be examined further.

Fissell draws attention to Josiah Tucker's Infirmary Anniversary Sermon of 1745, in which he emphasised the reforming function of the hospital. She points out that `the sermon was sufficiently consonant with the views of the governors that they had it published'.[23] In fact, it was the practice to publish all Infirmary Anniversary sermons.

In purely medical terms, some of the problems thrown up by Fissell's account can be noted immediately. In the late 18th century and early 19th, power passed, Fissell notes, from the Governors (i.e. Subscribers) to the surgeons.[24] At the same time as this power shift there was a change in attitude to the patients who, Fissell argues, came to be seen as objects of diagnosis and therapy rather than as sufferers with a story to tell. On both changes there is little doubt that Fissell is correct. However, her arguments for there having been a change in perception of the patients are suspect. She shows how written accounts of patients' sufferings change character, from reproductions of the patients' own accounts of their illnesses, to summaries with much description of bodily signs. Further, she interprets the patients' symptoms in these later accounts as having been given a place secondary to the physical signs. The logic need not be what Fissell indicates. In the period which includes Laennec (1781-1826), the French inventor of the stethoscope, and Skoda (1805-1881), the Viennese Czech who developed the systematic examination of the patient, the indicative signs that could be elicited or immediately observed increased greatly in number, with a corresponding increase in diagnoses reflecting underlying processes. This inevitably affected the way in which encounters with patients were reported. What the patient said and what the healer found would surely constellate in the latter's mind to form a more or less hypothetical complex. If the report or memorandum generated by this gave more prominence to signs than to symptoms, there was on that account no certain indication that the physician or surgeon had not begun his work on the patient's problem with an appreciation of the patient's perception of the trouble as narrated by the

patient. What would be important for the thrust of Fissell's argument would be a knowledge of how the patient was listened to. Here handbooks for students and junior physicians and surgeons might be useful. We know that, by the late 19th and early 20th century, the taking of a `history' had tended to become structured by asking the patient questions, many of them standardised. This tended to exclude the patient's spontaneity, so that the patient's perception of his or her disease would have become excluded or significantly structured, not only (if at all) by increased attention to physical signs, but by the very act of receiving the initial oral information. Fissell is probably correct to propose the change in medical attitude which she puts forward, and her evidence for the change is not to be neglected, but her presentation of this evidence as proof in itself of the change is not altogether justified.

The attitude of staff to patients in Bristol Infirmary in the early 19th century is, according to Fissell, changed by improved diagnoses and therapeutics. As an example of this `shift in authority from patient to pracitioner', as appertaining to therapy, she cites Bedingfield[25] (1816); `We are often reduced to the alternative of taking blood from the arm or of allowing it to rush from the lungs. Which mode I would enquire is attended with the greater hazard and inconveninece to the patient?' Fissell goes on to add `And inconvenience to the staff as well'. She sees bleeding as an administratively convenient way for a small staff to deal with the patients in 180 beds (in which year she does not say) and calls it `heroic therapy'. Bleeding, as Fissell rightly says, was commonplace in the Infirmary but usually was not sufficient to cause general discomfort. Standard practice was to take 12 ounces, although, as Fissell notes, much larger amounts might be taken in certain circumstances.[26] (A modern blood donation is about 14 ounces, that is, 420mls.) Bleeding can hardly have been an indicator of shift from patient authority, since it was popular and sought after by the

public. The procedure itself had, of course, been standard practice in Western medicine for at least one-and-a-half millennia. As for Bedingfield's words, they do not indicate a shift from anything at all, but conservative adherence to a Galenic doctrine according to which spontaneous bleeding represented a necessary evacuation (*kenosis*) for which controlled bleeding might substitute. (Galenism had received a severe blow from Paracelsus in the 16th century, and from Helmont and Harvey in the 17th, and was incompatible with the new clinical skills which gave rise to the body signs remarked on by Fissell, as noted above.[27]) Fissell makes the general point that there was loss by the patient of a say in what the treatment was to be, but it is not clear how much such choice was exercised in any age except by those rich enough to buy the consciences of their advisers. It would seem that a minority of advice has been of the form of an invitation to consider options, and the `patient's choice', a 20th century preoccupaion, has been otherwise exercised, if at all, by the crude method of refusing the first treatment offered.

The work by Risse on the Edinburgh Royal Infirmary is the most thorough on 18th century hospital data.[28] Risse uses the case-books for statistical analysis, just as Bristol Admission Registers are used here in the present study. However, Risse's work depends on randomised data, resulting in a sample of 3,047 entries taken from the General Registers of Patients at quinquennial intervals from 1700 to 1800. This present work relies on every entry in a single twelve month period, 3,402 entries in all, and so avoids any error due to pooling from a period in which there may have been a trend of consistent change. The purpose of Risse's work is to provide the social historian with a prototype of a new genre of institutional history as distinct from histories which tend to deal almost exclusively either with health professionals or the impact of hospitalisation on society. Risse is making a plea for `a "total" hospital history, a reconstruction of institutional activities that takes into account both

external and internal factors that are always inextricably linked together.'[29] Risse presented a method; here I am modifying and going beyond the method to show its applicability in just such a reconstruction as Risse would have.

Cherry, on the Norfolk and Norwich Hospital (1771-1880),[30] approaches his subject as a matter for research rather than, as generally in the hospital histories, for the declaring of a tribal lay.[31] He puts patients at the centre of attention, giving statistics of the claimed outcomes of treatment, but on the disorders complained of or diagnosed he makes only general remarks, and is not concerned with treatments. By inference from his work he is able to suggest[32]

> it is possible that not only did hospitals avoid increasing mortality within their own wards, but that some may also have made a partial, though positive, contribution towards improving health standards and reducing mortality rates in their own patient catchment area.

This suggestion is borne out in the present study, as it bears upon the practice of nursing and medical care at the Bristol Infirmary.

Brockbank on Manchester Infirmary,[33] Cameron on Guy's Hospital,[34] Clark-Kennedy on the London Hospital,[35] Lane on Worcester Infirmary,[36] Langdon-Davies on the Westminster Hospital,[37] Logan Turner on the Edinburgh Infirmary,[38] McLaughlin on the first Liverpool Infirmary[39] and Munro Smith on the Bristol Infirmary[40] all write administrative history, usually with copious material on staff, especially medical and surgical, although Munro Smith alone makes the staff central to his history. None of these authors makes patients central in his or her discourse. Cameron and Logan Turner grant them scant mention, while others introduce occasional illustrative anecdotes. Langdon-Davies is concerned with the human implications of decisions in hospital government, while Brockbank (an

unusually rich secondary source among hospital histories) pays considerable attention to conditions in Manchester outside the hospital. The social context of the hospital's work is not given by any of these authors the sytematic treatment which characterises their administrative history.

The development of the factory system after the time with which this study is concerned was accompanied by changes in the social setting of the hospitals. In Britain there followed the economic effects of the Napoleonic wars, and on the Continent society was changed by the events stemming from the Revolution of 1789-90. Generalisations about hospitals bear directly on Bristol Infirmary in 1761-2 only if they apply to these years.

In general, these sources on hospitals indicate that non-quantitative studies (except, creditably, Fissell's) are too narrow, when about one place, to give both a picture of the patient and a social context. Quantitative, and sometimes non-quantitative, studies conflate periods, and one study, that of Fissell's, appears to conflate places also. Where a study spans a stretch of time without a framework of sequential narrative, interpretations may become unifying themes to which the documentary evidence becomes fitted. The analysis of the records of the Bristol Infirmary in a single year reveals some of the fallacies and misinterpretations referred to above, demonstrating far more liberal administrative systems than might be inferred from Fissell's account, perhaps because of the conflation of the mid-18th century with later times, and thus revising the perspective she offers on the nature and role of Bristol's principal hospital of the 18th century.

The ebb and flow of charitable behaviour, with particular reference to its relationships with the medical profession, has been developed in a collection of works by Barry and Jones.[41] Relationships are also investigated from a variety of standpoints involving patients and Subscribers.

This collection of papers shows that a direct relationship between need and supply did not necessarily exist. Indeed, Cavallo's paper[42] makes it clear `that people often engaged in charity as a result of concerns other than those generated by thoughts of the poor'. The correlate of this is to cast doubt upon the received wisdom that the need for charity is father to its actions.

Jonathan Barry[43] reports original studies on Bristol showing how, in mid-18th century Bristol, piety, expressed in charitable works, united in common action people of various religious denominations, and he takes the establishment of the Bristol Infirmary as a case in point. He sees the plans for this institution, `both in timing and personnel as an attempted rapprochement between moderate Whigs and Tories, and an ecumenical gesture for non-denominational piety'[44]. The work reported in this thesis, while not having either political or sectarian distinctions as a central concern, confirms Barry's conclusions insofar as they relate to the matters in hand.

Rodgers[45] makes the point that it is often difficult to distinguish between charity and propaganda. In our own times, as earlier, charitable organisations not uncommonly are called into being in order to give maximum publicity to an unmet need in the community, and may result in the planned effect of forcing the State to accept obligations in the matter. To a certain extent 18th century voluntary hospitals also became a tool of social policy, but local, as well as national, policy, and probably not to put pressure on the authorities to take official action.

Andrew[46] has noted the value of the annual charity sermons at both the Lock Hospital and the Lying-In Charity for Married Women and writes of them;[47]

> These sermons were attempts to convince their audiences of the efficacy of their particular charity, and of its national social or policy value. Thus the charity sermons speak to us in voices louder than their own, for in many ways

> they articulated the hopes and motives of their audiences whose opinions otherwise are almost entirely unknown and unrecorded.

The Bristol Infirmary Anniversary Sermons are rich in allusions to charity and provide a contemporary view of its understanding. Particularly stressed is the need to make friends with the `Mammon of Unrighteousness'. This will be discussed in Chapter 3 and its possible efficacy noted.

The categories `economic and patriotic', `humanitarian' and `spiritual', as detailed by Lewis and Williams in their work *Private Charity in England 1747-1757,*[48] have also been used in Chapter 3 to structure the discussion on philanthropy. The period of Lewis and Williams' work makes it highly relevant to this present study and it will be noted that aspects of all the categories they define are apparent in the motivation of benefactors to the Bristol Infirmary.

There is therefore a place for a study such as that reported here. That year, 1761-2, just one generation after the opening of Bristol Infirmary, represents it at an early phase but after those first adjustments of policy which may be regarded as adaptations to initial experience. In the present study the Infirmary is related not only to the social and economic life of the city generally, but also to the history and work of the Corporation of the Poor. The investigations reported in this thesis deal in more detail, perhaps, than other studies on 18th century hospitals, with therapeutic efficacy, the dangers and benefits of admission to hospital, and some aspects of epidemiology.

0.4 THE ARRANGEMENT OF THE STUDY

In Part 1 attention will be paid first to the general character of Bristol in the period under investigation and then to the public services for the sick during the forty years before the first patient was admitted to the Infirmary

in 1737. It will then be possible to understand something of the reasons for the Infirmary's foundation and so cast an intelligent gaze over the founders' policies (Chapter 1). Further information on the exercise and exercisers of power in the Infirmary will be gained through considering Subscribers and the Infirmary's finances (Chapter 2), and some of the attitudes implied by the provision for the care of patients will be discussed in Chapter 3.

It will then be appropriate to turn, in Part 2, from those controlling the Infirmary to those using it and about these the surviving documents are a treasure trove of contemporary information. These sources enable us to learn something of the social and geographical groups who used the Infirmary, of their pathways of admission, of the social background to their infirmities, and something of the epidemiology of their diseases (Chapter 4). It then becomes appropriate to consider some features of the healing arts at that time and place, which is followed by a consideration of how effectively the Infirmary contributed to healing (Chapter 5).

The conclusions assess the findings of Part I and Part II. The usefulness of the Infirmary's medical care to the poor of Bristol is considered and a comparison is made with the medical services offered by the Corporation of the Poor. The discussion in this chapter next centres on the usefulness of the Infirmary to those providing it, with some reference to the question of social control of the poor, and a consideration of the meaning of the Infirmary's motto, `Charity Universal'. The Bristol Infirmary is then viewed in its context as part of the `British Voluntary Hospital Movement', and the place of the Infirmary in the social structure of the city discussed. It then remains to draw general conclusions from this study of Bristol Infirmary in the twelve months from Michaelmas 1761 to Michaelmas 1762.

PART 1

POWER IN THE INFIRMARY

CHAPTER 1

The establishment of power : Bristol Infirmary's origin, social relations and admission policy.

1.1 INTRODUCTION

In order to understand the genesis of Bristol Infirmary it is necessary to have some picture of Bristol itself in the early 18th century. After an historical note this chapter will first, therefore, briefly review six aspects of Bristol life at that time: social dynamics, religious denominations, culture and politics, the economy of the city, the condition of the poor, and the size of the population. Each of these characteristics has a bearing upon the origin or purpose of the Infirmary. Reviewing them also relates the early Infirmary to its geographical place and period.

The second major consideration will be the Bristol Corporation of the Poor. When the Infirmary was opened in 1737 there were already services for the sick provided by this body. In this chapter note will be taken of the origin and character of the Corporation, of its provision for the sick poor, of opposition to the Corporation and of the Corporation's hospital.

The work then analyses certain features of the Infirmary itself. After some characteristics of its inception and government have been noted the admission policy is examined, cognizance being taken of the criteria of eligibility to be a patient, of the means of admission and of the distempers and groups of patients excluded by the Rules. It will be shown that the Infirmary was an acute hospital and maintained as such through Rules governing

admission and length of stay. The problem of having insufficient beds to meet demand will be discussed, as will some differences between admission policy according to Rules and according to practice. Concerning admission, attention will finally be given to the rights and duties of the Subscribers in this matter.

There is then a summary of the distinctions of function between the Corporation of the Poor and the Infirmary and the chapter concludes with a note on the Infirmary's subsequent history.

1.2 BRISTOL IN THE MID-18TH CENTURY

Although the present suburbs of Bristol include Iron Age forts, two Roman villas, the Roman port of Abonae (Sea Mills) and the site of an Anglo-Saxon monastery, the city itself is no older than the early Middle Ages. Already, however, in Domesday, Bristol's estimated revenue was as high as that of Norwich, York or Lincoln[1] and the Calais Muster of 1346 makes Bristol almost equal to London in ships and crews.[2] Bristol's wealth having aided Edward III in his French wars, the King in 1376 awarded the city the status of a county (which status it only lost 600 years later with the formation of the County of Avon) with the right and duty to send two burgesses to Parliament. Although weaving became an important industry from the 14th century, it was in general true that mediaeval and early modern Bristol subsisted more by trade than by manufacture.[3]

By the close of the 17th century the population numbered 20,000 with a 11:9 ratio in favour of females and with St James, which combined central density with some suburban expansion, being by far the most populous parish.[4] Various assessments have been carried out for the following century and reveal a steady increase.[5] A high population being desirable for `the riches and power of a nation', this increase was felt to be commendable.[6] Over the same period the population of England nearly doubled.[7]

Migration would have played a major part in Bristol's population increase and entrepreneurs moving into the city found that it was not impossible to break into the Guilds. Not all prospective traders or merchants were being subjected to a fine to smooth their pathway into obtaining the freedom of the city, particularly if nominated by a freeman of good standing.[8] The training of apprentices, the lure of a big city, life in a bustling seaport, the hope of employment opportunities, each would have had its effect in adding to the size of the population. It is debatable how far enclosures would have affected Bristol's population, for enclosure in the West Country was already of long standing. Nevertheless, enclosure increased in, for example, Gloucestershire and this, together with the rapid growth of enclosure generally throughout the country, suggests that there would still be a large class of very poor people roaming the countryside and some, at least, would have found their way to Bristol.[9] Neither need all sailors settling from seafaring into Bristol have been Bristolians by origin, for their work could have led to familiarity with the city, and discharge there.

During the 18th century much of the town centre was laid out in squares of fine Georgian houses, Queen Square and King Square being the finest examples of the new building. The rich merchants were thus able to occupy elegant accommodation in accord with their status. The new suburbs - Redland, Kingsdown and St James out-parish - also became predominantly the domain of the wealthy and their domestic servants. At the same time much of Bristol was cramped, densely populated and dirty.

Although it is held in the Catechism that one is to `do my duty in that state of life unto which it shall please God to call me', many were happy to respond to a call to a higher social standing and to climb at least the first rung on the ladder of upward mobility and, the parliamentary electoral vote being the privilege of a free burgess or freeholder, it was a state to which, it might be

thought, many of the unenfranchised would aspire. At the time of a general election parliamentary candidates would willingly, indeed actively, seek to purchase a citizen's `Freedom of the City' in return for a favourable vote. In 1754, 986 Bristolians acquired their `freedom' in just this manner.[10] Had Dean Tucker, at the time of his preaching the 1745 Anniversary Sermon, a premonition concerning this event, no doubt his comments would have been even more scathing, were that possible, than those which are now quoted![11]

> Our People are *drunk with the Cup of Liberty*. They enjoy it to a degree unknown to our Forefathers, who lived in a State of *Vassalage* and *Dependance*, little better than that of Bondage and Slavery; and who by this Means were habituated to think, that it was above their Sphere, and fitting only for their Superiors, to gratify themselves in Scenes of expensive Pleasures, and criminal Diversions. But their Posterity have been growing up into Freedom for several Generations back, and are now become entirely independent, and Masters of themselves, and their own Actions. Their Minds and Inclinations are now set loose to think, and judge, and do as they please. In short, our Constitution is so much altered from what it was in former Times; partly by the prodigious sinking of the Valuation of Money, which has *accidently* let in the whole Body, and even the meanest of the People to be equally concerned with the greatest, in the Choice of Representatives; and partly by other Contingencies too tedious here to mention; that one might almost say, the lowest of the People are now become the ultimate Judges of Publick Affairs, and that they are regularly appealed to, at the Expiration of a certain Period of Years, if not oftener, for their express Verdict and Decision.

In fairness to Dean Tucker though, it must be recorded that he was a leading campaigner for the abolition of slavery[12] and campaigned for the naturalisation of foreign Protestants and Jews.[13]

In any event, by 1761 the 18 parishes of Bristol had 5,000 names on the electoral roll[14] out of a population of about 38,000.[15] In the size of the roll, Bristol was

third after Westminster and London, there being only 85,000 electors in the whole country.[16]

1.3 WORSHIPPING GROUPS IN BRISTOL

The variety of Bristol life in the 1760's is exemplified by the variety of its worshipping groups. If, in Bristol, the Church of England had, as it still has, churches of surpassing beauty, inviting prayer `where prayer has been valid', the Dissenters made for themselves numerous meeting houses of the quiet dignity which goes well with depth of worship, the soaring of the spirit being a matter of song (or silent Quaker worship) more than stone.

In 1640, nearly half a century before the Toleration Act of 1689, the first dissenting church in Bristol was built.[17] Very early in the history of this church its adherents adopted the doctrines of the Baptist faith. A Baptist church still stands on this site. Just 35 years after the Act Defoe could list 7 out of 26 places of worship as dissenting, `two Presbyterian, One Independent, two Quakers, one Baptist; also one or two other meetings not to be nam'd'[18] and Methodism was yet to develop! There was also a synagogue. By the middle of the 18th century it has been estimated that 20% of the population were dissenters.[19]

As to the contribution of Protestants to the worshipping life of Bristol, Matthews writes,[20]

> There are also places of worship for all the denominations in England that are popular and prevalent; whose adherents live in harmony, if not charity; who meet and mix without malevolence and occasionally lend an ear to each others preachers.

The records of the Catholic Record Society indicate that a Roman Catholic chapel in Trenchard Lane, Bristol was in use from 1777[21] and Matthews writes that both Papists and Protestants contributed to its erection,[22] and we may suppose there to have been Catholics, of the number

such as is thus indicated, in the city already in the 1760's.

As will be explored later, whether or not the adherents of most denominations lived in charity, they certainly co-operated in public giving. However, no Infirmary Subscriber of the Roman Catholic persuasion has been identified, though it must be said that records relating to Bristol Roman Catholics of this period are very sparse. The relaxed interdenominational relations in Bristol are reflected in the government of the Infirmary, an example of what Barry calls 18th century Bristol's ecumenism.[23]

1.4 NEWSPAPERS, POLITICS, AND ECONOMICS OF BRISTOL

In 1761 the city readership supported two weekly newspapers: the Bristol Journal and the Felix Farley Bristol Journal, in addition to a well-stocked Subscription Library and five booksellers, the trade of bookselling then including publishing. Bristol's public library dated from 1613, the first of its kind in the country. Entertainment could be found at any of the numerous glee clubs, balls, dinners, concerts, cock fighting venues etc.. Political clubs proliferated and the Whigs enjoyed continuing supremacy in them, as in that doyen of Bristol societies, the Society of Merchant Venturers.

In fact, political loyalty to Bristol tended to over-ride loyalty to party. The city chose Members of Parliament to represent its own interests and the two seats might go to candidates of opposed parties. Indeed, the ample Bristol Poll Books, which recorded each elector's votes in the days before secret ballots, show that it was common for one man to give his two votes for candidates of different parties. From 1754 to 1774 Bristol had one Whig and one Tory Member of Parliament, although the city corporation was staunchly Whig. Local interest might, however, sometimes take second place, as in 1774 when the

two Whigs, Edmund Burke and Henry Cruger, were elected to Parliament. At the declaration of poll Cruger promised to obey his constituents' instructions. In reply, Burke spoke: `He owes you not his industry only, but his judgement; and he betrays instead of serving you if he sacrifices it to your opinion'.[24] Burke was cheered and carried shoulder-high. Nevertheless, local interest finally prevailed and in the 1780 election Bristolians made it clear to Burke that his advocacy of the commercial rights of Ireland, which were not agreeable to the advantage of Bristol merchants, would prevent his future election by the city.[25]

A certain independence of spirit is noted by Matthews in praising his fellow-Bristolians.[26]

> The lowest classes are sharp, witty, droll, saucy, profligate and fraudulent.... The populace are apt to collect in mobs on the slightest occasions; but have been seldom so spirited as in the late transactions on *Bristol-bridge*....

where they abolished the tolls by an incendiary riot which cost some of them their lives.

The economic activity underlining this variety of taste, thought and attitude was itself richly varied. The building, re-fitting, equipping and stocking of ships to make them `shipshape and Bristol fashion' required a wide range of crafts and commerce. In addition there was a requirement for goods for export, some part of which would participate in the triangular trade of slaves shipped from Africa to America and exchanged there for tobacco and sugar before the journey back to England. The wealth arising from shipping and commerce encouraged manufactures also by providing a home market for goods of quality and luxury.

In a 20th century manuscript copy of a list originally compiled by Isaac Cotterell in 1768, the names, addresses, and occupations of all the merchants and tradesmen in Bristol are stated to be recorded.[27] Fifty-nine different trades are noted although `merchants' are a

single trade not further described. The tradesmen include bakers, fishmongers and grocers; haberdashers, hatters and hosiers; blacksmiths, carvers, saddlers and coach makers; pipemakers, potters and printers; `salt Men for export' and `Stone Cutters for Export'; shipwrights, vintners, silk mercers, linen drapers and cotton dealers; braziers, glassmakers, limeburners and iron warehousers.

Even more trades are to be found in Sketchley's Directory of 1775; pawnbrokers, apothecaries, peruke makers, wine merchants, ships' captains, brassfounders, corkcutters, silversmiths and goldsmiths among them.[28] Unlike Cotterell's list this document notes non-commercial occupations. Attorneys, public notaries, bankers, officers of excise and sworn measurers appear. The frequency with which the title `ship's captain' occurs is further indication of the very large overseas trade. The regions of this trade are further indicated in Sketchley's Directory.

> Brailsford Samuel, Carolina,..... 29, College-green
> Coghlan Jeremiah, Newfoundland,... 9, Trinity-Street
> Davis Mark, West India,..... 15, Orchard-street
> Farell & Jones, Virginia.....36,Queen-square
> Gibbons & Sons, Russia,.....54,Queen-square
> Powell John, Guinea,.....30, College-green

The number and variety of occupations noted here was a feature of Bristol which had been developing over the previous two centuries. Minchinton sums up Bristol's external economy thus;[29]

> The Eighteenth Century was Bristol's golden age. For most of this period, except for London, Bristol was the leading English port.... For long Bristol had been an important seaport, most of its trade being carried on with markets near to hand in Ireland, France and the Iberian peninsula. During the eighteenth century Bristol merchants continued to engage in these trades but her pre-eminence in that century was based on new trades, on the growth of transatlantic commerce. From about the mid-seventeenth century, trade with Virginia, the Carolinas and the West Indies had begun to grow. The tonnage of shipping entering the port from the West Indies rose from 1,900 in

> 1670 to 5,200 in 1700: in 1659/60 14 ships came from Virginia, in 1699/1700 the number had increased to 29. And to the sugar and tobacco trades, as a result of the Acts which permitted anyone to trade with Africa, on payment of a ten per cent tax on imports and exports, was added in 1698 that most contentious of trades, the slave trade. The pattern was set for the following century. Rum, slaves, tobacco and sugar were the main ingredients of Bristol's prosperity in the eighteenth century, with sugar the most important.

Concerning the contentious trade of slavery, MacInnes argues that it is probable that Bristol never was the principal slave port of the kingdom.[30] However, he concedes that it is likely that Bristol gave place only to London and Liverpool in this source of notoriety. In 1725 Bristol ships were responsible for transporting 16,950 slaves to the New World. It was a traffic engaged in by the most reputable, even if judged odious by future generations.[31] Trading in slaves had been condemned by George Fox, founder of the Quakers, in 1671. In 1727 the Quakers declared it to be `not a commendable or allowed' practice and in 1761 excluded from the Society of Friends all who took part in it. In 1776 David Hartley unsuccessfully moved a motion in the Commons against the trade, with Wilberforce resuming his anti-slavery activity in the House in 1789.[32] Against this background of increasing concern we may ask whether we need to define more exactly `the nation as a whole' in the following comment by MacInnes, if it is to be applied to 1761, the year when the Quakers, active and influential in Bristol, exercised their final and strongest possible disassociation from the trade.[33]

> In the course of the eighteenth century mayors of Bristol, sheriffs, aldermen, town councillors, Members of Parliament, the Society of Merchant Venturers and, indeed, men of the highest repute in the place were engaged in this traffic. These were not wicked men but pillars of society in their own time.... If these men are to be judged then it should be by the moral standards of the time in which they lived. Since the nation as a whole at that time condoned their activities and applauded them for their enterprise, there would

appear to be no special reason why they should be selected for particular condemnation.

Bristol's inland trade had continued to flourish in the thirty-five years following Defoe's observation,[34]

> But the Bristol merchants as they have a very great trade abroad, so they have always buyers at home, for their returns, and that such buyers that no cargo is too big for them. To this purpose, the shopkeepers in Bristol who in general are all wholesale men, have so great an inland trade among all the western counties, that they maintain carriers just as the London tradesmen do, to all the principal counties and towns from Southampton in the south, even to the banks of the Trent north; and tho' they have no navigable river that way, yet they drive a very great trade through all those counties. Add to this, That, as well by sea, as by the navigation of two great rivers, the Wye, and the Severn, they have the whole trade of South-Wales, as it were, to themselves, and the greatest part of North-Wales; and as to their trade to Ireland, it is not only great in it self, but is prodigiously encreas'd in these last thirty years, since the Revolution, notwithstanding the great encrease and encrouchment of the merchants at Liverpool, in the Irish trade, and the great devastations of the war; the kingdom of Ireland it self being wonderfully encreas'd since that time.

With a need to integrate the newly prosperous into the civic community and a city with such diversity of spirit, wealth, religious affiliation and political views as we have shown Bristol to be, the Infirmary could well have been the unifying factor necessary to avoid factionalism with a consequent loss of civic pride. Castelman, preacher of the 1743 Anniversary Sermon, was aware of the potential of the Infirmary to combat this.[35]

> ...and this [the Infirmary] I would recommend heartily on a double Account; for it will not only perpetuate our good Will to the poor Sick - but naturally create or improve that to one another: If ever *the Walls of our* Jerusalem *be built up* - our shameful pernicious Divisions in Church and State be perfectly healed, Infirmaries probably will contribute greatly to the desirable End; in Infirmary Meetings must unite all Parties, and all Denominations- and all in good Humour;- the Extravagance of Party-Fury subsides: Each, conscious that his own Motive is to do good,

> naturally concludes, all attend with like Dispositions; hence we sit, we converse together, and whom before, perhaps for no stronger Reason than Difference in political Principles, we begin now to treat as human Creatures - nay, fellow Christians, Reverers of God and *Christ*, and Lovers of Mankind.

To conclude this bird's-eye view of sources of Bristol's wealth in 1761-2, note should be taken of the Seven Year's War then being fought between Britain and Prussia on the one side, with France, Austria, Russia and Sweden on the other. Maritime Bristol's interests in the fortunes of a war, which included a struggle for sea power, is evident, for Bristol also built, fitted, serviced and repaired naval as well as merchant ships.

1.5 THE POOR OF BRISTOL

Little or nothing is recorded by the poorer inhabitants of Bristol of their perceptions of life in the city but it is enlightening to note certain employment conditions with which they had to contend. It is difficult to get precise wage levels for a short period in a particular location, but John Latimer gives the following figures for the period 1747-68 for local employment.[36] (The relevant year is shown in brackets.)

> Journeyman carpenter; 1s 10d per day (1747):
> Itinerant preacher; less than £1 1s 0d per week (1753):
> Taylor; 1s 9d per day for a day of 13 hours (1755):
> Carpenter; 1s 2d per day (1766):
> Agricultural labourers of Gloucestershire; from 4s 0d to 5s 0d per week in winter and 6s 0d per week in summer.

An Anniversary Sermon of 1757 suggests that, in some respects at least, there was a shortage of labour.[37] In principle, this shortage should have favoured wage-earners but there appears to be little respite in the poverty they were called upon to bear.

Children, even of young age, would be expected to make a contribution to family resources either through domestic usefulness or by assisting with their parents' employment. We have, however, no evidence that, at this period there was systematic exploitation of child labour in Bristol. It was perhaps more a case of children participating in the adult lifestyle.

A darker side of Bristol life is shown by Latimer, writing of a period around 1758.[38]

> A singular business was carried on at this period by a midwife living in Maudlin Lane, who announced that she conveyed or sent children every Wednesday to the Foundling Hospital in London, her charge to parents desirious of ridding themselves of their offspring being 2 1/2 guineas for each child, or four guineas for a couple. As the advertisment was repeated for some months, the woman seems to have found the traffic profitable.

Latimer's report may be better understood by reference to B. Abbott Seagraves' work on infanticide quoted by Germaine Greer.[39]

> Disguised infanticide was a further limiting device prevalent throughout Western Europe in the late eighteenth and early nineteenth centuries.. Langer...provides vivid documentation of this widespread practice as it was systematically carried out in England and France. The London Foundling Hospital, which after open admissions in 1756 was to accept some 15,000 children over the next four years, was called by one of its govenors a "slaughterhouse of infants" because the mortality there was nearly equal to its admissions.

It is not immediately obvious who would have used the service of this midwife. The wealthiest would scarcely have needed it and the poor could not have afforded it although the wealthy may have paid on behalf of the badly off, a mistress for her maid for example, particularly perhaps, if an illegitimate offspring had been fathered by a member of the household. It is well to keep a matter such

as `disguised infanticide' in mind when considering the city's apparent sturdy religiosity.

The following excerpt, taken from the diary of a Swedish spy, Ferner, is dated 9th January, 1760. Whether or not it throws light on the source of infants transported to London, it does at least remind us that, even among the badly off, priorities in spending may not be what economists suppose.[40]

> After this conference I went through Temple Gate, 1 mile from the town, to Knoll [Knowle], where 1,200 French prisoners of war are kept. The cold was now very bitter, the window-apertures all open and their curtains in the most deplorable condition, of which, when I pitied them in a conversation with an Englishman who was there, he said:
>
> "They in truth are to be pitied, but not so much as you believe; because not only do they receive 6 pence a day for food but also people collect clothes for them. Many of the clothes they have sold for ready money without using any of it for food or drink as they do not spend more than 6 pence a day and often not even that".
>
> I asked:
>
> "Do they save a lot of money during their imprisonment to be able to keep warm by buying suitable clothes?"
>
> To which question he answered:
>
> "Certainly not, but if they did not sell clothes, how would they be able to afford from time to time the visit of girls, without which, they say, they cannot live?"
>
> I continued my walk a bit further, then returned and met some milkmaids, that were more gaudily dressed than usual. I asked them where they were going so late with milk.
>
> "To the French gentlemen", they answered pertly. I asked them if the Frenchmen could speak with them.
>
> "Yes, yes", they answered all together, adding that they had taught them most of their English. From this as well as some other answers I understood that the Englishman had told the truth

> and that these nymphs were precisely those who had rigged those poor Frenchmen and exposed them to this cold, unusually severe for this place.

Three months before this incident took place John Wesley was also in Bristol and records in his diary for 15th October, 1759 that[41]

> I walked up to Knowle, a mile from Bristol, to see the French prisoners. About eleven hundred of them, we were informed, were confined in that little place without any thing to lie on but a little dirty straw, or any thing to cover them but a few foul thin rags, either by day or night, so that they died like rotten sheep. I was much affected, and preached in the evening on (Exodus XXIII. 9), `Thou shalt not oppress a stranger, for ye know the heart of a stranger, seeing ye were strangers in the land of Egypt.' Eighteen pounds were contributed immediately, which were made up four-and-twenty the next day. With this we bought linen and woollen cloth, which were made up into shirts, waistcoats, and breeches. Some dozen of stockings were added; all which were carefully distributed, where there was the greatest want. Presently after, the Corporation of Bristol sent a large quantity of mattresses and blankets. And it was not long before contributions were set on foot at London, and in various parts of the kingdom; so that I believe from this time they were pretty well provided with all the necessaries of life.

Those who wished to make religiosity more widespread might be willing to coerce others into the practice. Latimer quotes from Felix Farley's Journal of 11th June, 1757.[42]

> We hear that the churchwardens of a considerable parish in this city intend (conformable to the obligations of their oath) to put the laws in force against all those within the said parish who commonly absent themselves from the publick worship on the Lord's Day; and also against common swearers, drunkards, &c., and its hoped and much to be wish'd that an example of this kind will be followed by all others who are well-wishers to the country.

Latimer proceeds to say that the fine for systematic neglect of public worship was set at £20 a month and 1s 0d for each casual default but that there appeared

to be no attempt to enforce the law. If this was an attempt to impose some control on the poor, the size of the fines - £20 a month! - would have made the law unenforcable, even if proclaiming it may have made some people feel better. This was probably all part of the late 17th and early 18th century interest in `the improvement of manners' aimed at the restless masses, even if an unenforcable law suggests a gesture rather than something ever believed effective.

Some would attribute poverty to the fault of the poor. The Revd. Tucker, preaching his 1745 Sermon, pointed out:[43]

> Moreover, how thoughtless and improvident is the *Labourer* and *Manufacturer*; inasmuch as in Times of Plenty, or when Work may be procured, and Trade is flourishing, you never lay up against a time of *Sickness*, or *Scarcity*, or *Deadness* of Employ?

It is interesting that in this passage Tucker lumps labourers together with manufacturers as representatives of the poor. (`Manufacturer' in this period is consonant with a skilled artisan such as a weaver or joiner.)

In 1761 conditions in Bristol's Newgate prison drew from John Wesley observations which he communicated to the editor of the London Chronicle. Below is a quotation from his letter.[44]

> SIR,
>
> Of all the seats of woe on this side hell, few, I suppose, exceed or even equal [London] Newgate. If any region of horror could exceed it a few years ago, Newgate in Bristol did; so great was the filth, the stench, the misery, and wickedness, which shocked all who had a spark of humanity left.

Wesley's first visit to Bristol was in 1739 when he came to meet the evangelist and preacher, George Whitefield.[45] It was in this city that Wesley's outdoor preaching ministry began[46] and it was this city that was

destined to become the first principal centre of Methodism. In the very early days of this visit Wesley made his initial acquaintance with Newgate prison and he records in his Journal that he preached to the prisoners from St John's gospel, and that `I also daily read the Morning Service of the Church'.[47] He does not mention the conditions which ruled then as a fore-runner of those which were to cause him such concern in 1761.

1.6 VISITORS' VIEWS OF BRISTOL

The impression made by Bristol on other visitors varied with the visitor. Defoe seems to have liked what he saw.[48]

> The city has of late years been newly paved, with smooth pavements on the side for foot-passengers, executed very neatly. It has been long lighted with lamps; but of late they have been increased, and the lighting is exceeded only in London. The city has plenty of good water from public pumps and conduits; The most remarkable of which is in Temple-street.... Also the river water is brought underground into every street, and may be had in every street, and may be had in every house for an annual payment. There are vaults or common sewers...and perhaps there is not a house which has not a communication with the main sewers; a provision for cleanliness, not so universal in any city in the world.

A contemporary of Defoe, Thomas Cox, draws attention to the effects such high levels of activity were having upon the citizens. He compared them unfavourably with their Bath neighbours and found them to be overwhelmed by their own `busyness'.[49]

> Bristol is very populous, but the people give themselves up to trade so entirely that nothing of the politeness and gaiety of Bath is to be seen here; all are in a hurry, running up and down with cloudy looks and busy faces, loading, carrying and unloading goods and merchandizing of all sorts from place to place; for the trade of so many nations is drawn hither by the industry and opulency of its people.

Alexander Pope could find no `civilisation' amongst the local population.[50]

> The City of Bristol itself is very unpleasant and no civilized Company in it.

Horace Walpole was even more devastating on his visit to the city in 1766.[51]

> I did go to Bristol, the dirtiest great shop I ever saw, with so foul a river, that had I seen the least appearance of cleanliness, I should have concluded they washed all their linen in it, as they do at Paris.

The River Frome, and later, the Floating Harbour was effectively an open sewer until 1962, when the new Avonmouth sewage works was constructed.

Visiting the city in 1752 an `Irish Gentleman', referred to by P. Marcy, makes this comment.[52]

> The Town itself is but disagreeable; the streets are generally dirty and close built, except a few which lie from the main body; but what contributes more to its disadvantage is the muddy river which flows in it, and this circumstance, in my opinion, cannot be compensated by any natural advantage.

The views of the `Irish Gentleman' are backed up by those of the government spy and agent, R.J. Sullivan.[53]

> When we consider Bristol as a place of trade and riches we are greatly surprised to find the houses so meanly built, and the streets so narrow, dirty, and ill-paved.

However, Bristol's poor would not have suffered unseen for it is obvious that the city was most crowded and compact. The parish of St James, the most populous parish in the city was, for instance, the home of many wealthy merchants; it was also a slum area where the very poor eked out their existence. Personal contact between worker and employer, street beggar and promenader, house servant and mistress, petitioner for relief and Subscriber, must have

brought to the notice of the wealthy the depth of need experienced by a large proportion of their fellow-citizens.

It has not proved possible in this study to link these conditions, with certainty, to distempers recorded in the Registers. Much disease due to bad hygiene, diarrhoea for example, may seldom have been presented at the Infirmary but we know that there certainly were sources for what we would now call malaria.

1.7 THE POPULATION OF BRISTOL IN THE 1760'S

The foregoing remarks are intended to draw attention to those features of Bristol life which are relevant to the Infirmary and its patients. One matter, however, requires a greater attempt to exactness, namely, the size of the city's population, since the size of the Infirmary and the rate of admission to it must be related to the population it served if we are to be able to estimate the hospital's possible importance to its citizens. A hospital with which only a few are acquainted does not feature in the consciousness of the public as does a hospital of which nearly everybody knows somebody who has been a patient. It is therefore essential to know what was the population of Bristol at this relevant time. For a city which was undergoing the fastest proportionate expansion in its history, certain difficulties in determining this present themselves but a final approximate figure has been arrived at.

A manuscript by Browne Willis, housed in the Bodleian Library, lists the number of houses in Bristol by parish for the two years 1712 and 1735.[54] The total numbers were 4,311 and 5,701 respectively. The 1712 figure was based on a survey carried out on the authority of the Bristol Corporation of the Poor as a prelude to petitioning Parliament for power to levy a higher rate, owing to `the city being considerably enlarged, and its inhabitants increased.' The 1735 figure is apparently based on Browne Willis's direct observation.

Browne Willis's manuscript is copied by the Cambridge antiquary, the Rev. W. Cole, and to this Cole appends his own note.[55]

> In 1752 I [sic] was at Bristol increased above 2000 since 1735. Burials in St. James's Parish about 400 a year. In St. Phillip's more a new Parish taken out of St. P's called St. George's. Br: Willis.

This document is bound into `Various Parochial Antiquities,' vol. X, one of the many manuscript volumns bequeathed by the Rev. W. Cole to the British Library. Pugsley suggests that half of these 2,000 houses were built outside the city[56] and I see no reason to disagree with his estimate. The housing stock of the city in 1752 would therefore have stood at about 6,700.

Estimates of the average number of persons per house at around this period vary. James Sketchley proposes a figure of 5 1/16 for Bristol, Clifton and Bedminster when empty houses are included in the equation,[57] and Pickhard suggests up to 6 1/2 when occupied houses are taken alone.[58] Stephen Hales, Rector of Teddington and Farringdon, Hants. (and first measurer of blood pressure), states that London, in about 1740, had a density of 7.5 to a house.[59] However, using Sketchley's very precise calculation of 18 Bristol streets[60] we find the occupancy of inhabited houses in the city to average 5.7.

The work by John Browning uses a different computational system from the two previous authors.[61] Browning estimates a population figure of 43,275 by burials and 43,692 by the houses rated at Michaelmas 1751. When his `computed' 1,200 houses in the out-parishes are subtracted, a total of 6,082 houses are left. Using Browning's estimation of 6 persons per house the number of inhabitants within the city would then have reached 36,492; a figure remarkably close to that already inferred from Rev. Cole's note on Browne Willis's manuscript taken together with Alfred Pugsley's later adjustments, i.e. 38,196. John

Browning's sets of figures give credence, each to the other, by the close resemblance arrived at by the two different methods, methods which are still acceptable to present-day demographers.

Sketchley calculated the number of houses in Bristol, Clifton and Bedminster to be 6,818.[62] Pugsley suggests that from this number a round 500 should be subtracted to account for Clifton and Bedminster, thus giving a net total of 6,300 houses.[63] He also concurs with Browning that small tenements, hospitals and almshouses, not included in that total, are equivalent to 1,216 houses.[64] A final figure of 7,516 houses is then reached. Allowing an average accupancy of 5 1/16, a population figure of 38,049 is arrived at.

A summary of the adjusted findings of these three men, together with that of the Rev. W. Cole, is given below (Fig. 1.1, p.35), with the number of inhabitants either stated in, or calculated from, their individual data.

Browne Willis, John Browning and James Sketchley were all possessed of local knowledge. Browne Willis, an eminent antiquarian, resided in the city for some time and had many local friends.[65] John Browning, domiciled at Barton Hill, Bristol, was amongst the founding Subscribers to the Bristol Infirmary.[66] James Sketchley, printer and auctioneer of 27, Small Street, Bristol was the publisher of the first Bristol Directory. He was also well-known locally for his completed plan to number, in sequence, the dwellings of the upper class and commercial residents of the city. For a consideration of 1s 0d he was further prepared to affix the number to their door.[67]

For the purpose of this work we have therefore taken the figure of 38,000 to be the nearest estimate of the number of inhabitants within the city boundary in 1761-2.

The outer city parishes (2201-2208), that is, those reaching the city boundary, (see Map 2 in Appendix 2) are the most abundant source of Infirmary patients. These parishes are much larger in area than the inner city parishes and therefore presumably in population. Fig. 1.2 (p.36) is a chart based on Browning's estimate of Bristol's housing stock as distributed by percentages and by actual numbers between the three areas, St. James parish (1101), inner city (2101-2109) and outer city (2201-2208) together with the distribution by percentage of In-patients and Out-patients within each of these three areas to enable comparison of housing stock (and therefore, potentially at least, of population) and Bristol Infirmary admissions to be made.

Fig. 1.1 THE POPULATION OF BRISTOL IN THE 18TH CENTURY*

AUTHOR	DATE	HOUSES	INHABITANTS
Browne Willis	1712	4311	24573
Browne Willis	1735	5701	32496
John Browning	1754	6082	36492
Rev. W. Cole	1752	6701	38196
James Sketchley	1775	7516	38049

AUTHOR	DATE (Based on)	BURIALS	INHABITANTS
John Browning	1741-1750	17317	43275

*The calculation of inhabitants from the number of houses and the number of burials according to Browning (1754) and Sketchley (1775) is due to the authors. Browne Willis (1735) and Cole (1752) estimate houses only and the number of inhabitants is derived from the number of houses, by multiplying the number of houses by 5.7, a factor due to Sketchley.

The number of patients originating from St. James and the outer city parishes appears to be rather greater than the corresonding proportion of houses. It needs to be emphasised that in general throughout this work formal

statistical analysis has usually been avoided because either the data are too sparse, as with some distempers, or the information is approximate, as in this use of houses. What is offered here are indications only.

Fig. 1.2 DISTRIBUTION AND NUMBER OF HOUSES WITHIN THE CITY OF BRISTOL, TOGETHER WITH THE NUMBER OF ADMISSIONS TO BRISTOL INFIRMARY, 1761-2

ZONE	HOUSES (1751)	IN-PATIENTS (1761-2)	OUT-PATIENTS (1761-2)
St. James (1101)	(20.8%) 1010	(33.6%) 233	(27.6%) 565
Inner city (21--)	(24.6%) 1194	(14.9%) 103	(12.7%) 261
Outer city (22--)	(54.6%) 2652	(51.5%) 357	(59.7%) 1222

(Numbers of houses based on Browning 1754)

Figs. 1.3 and 1.4 are scatter diagrams for In- and Out-patients respectively, produced to indicate whether there might be any proportionality between the number of houses in any given parish and the number of patients coming to the Bristol Infirmary from them. The diagrams suggests that Sts. Philip and Jacob sent far more patients than the size of its

Fig. 1.3 IN-PATIENT ADMISSIONS FROM CITY PARISHES TO BRISTOL INFIRMARY, 1761-2, COMPARED WITH NUMBERS OF HOUSES IN 1751 (BROWNING, 1754). (Parish code numbers are those allocated in the present study.)

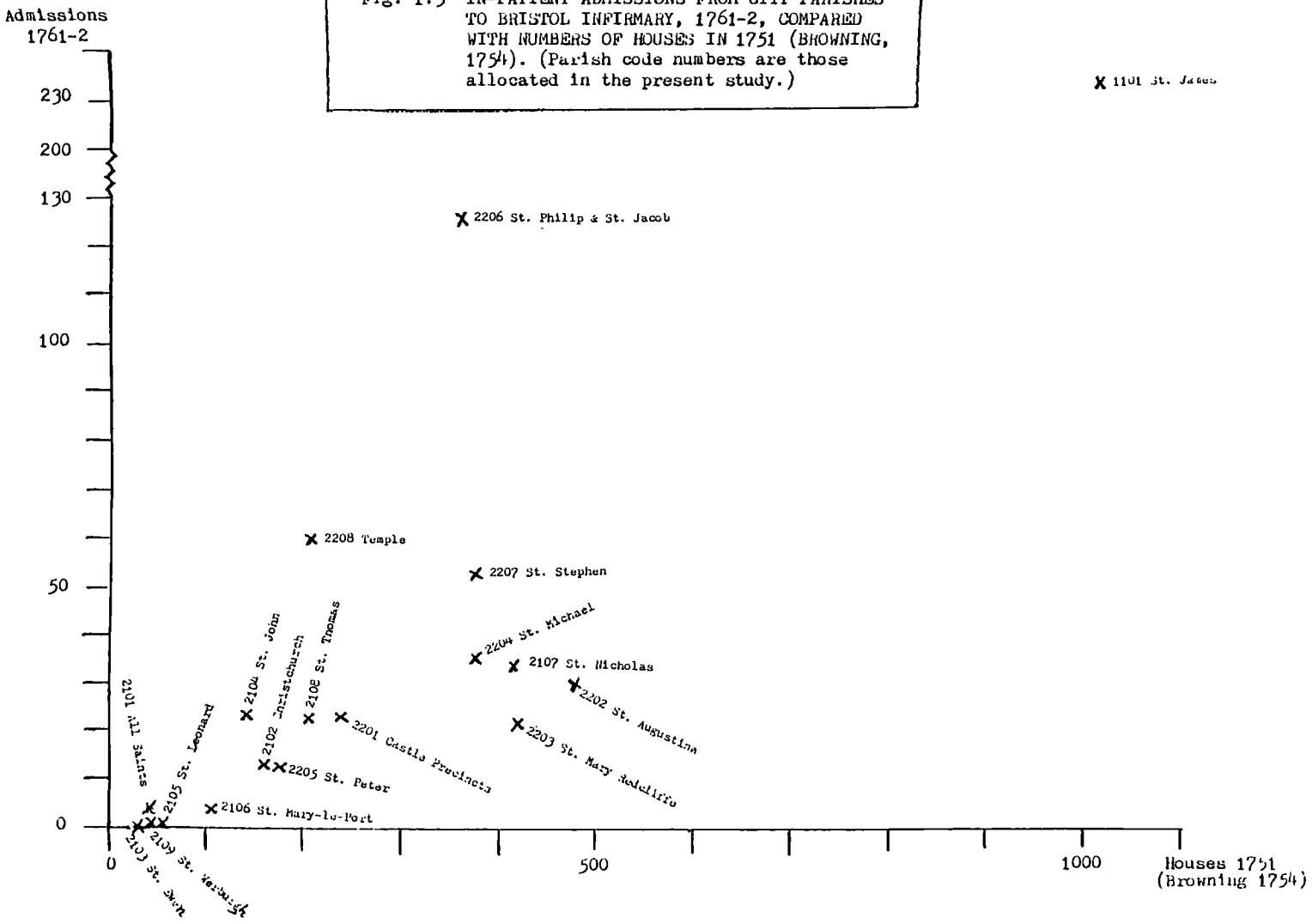
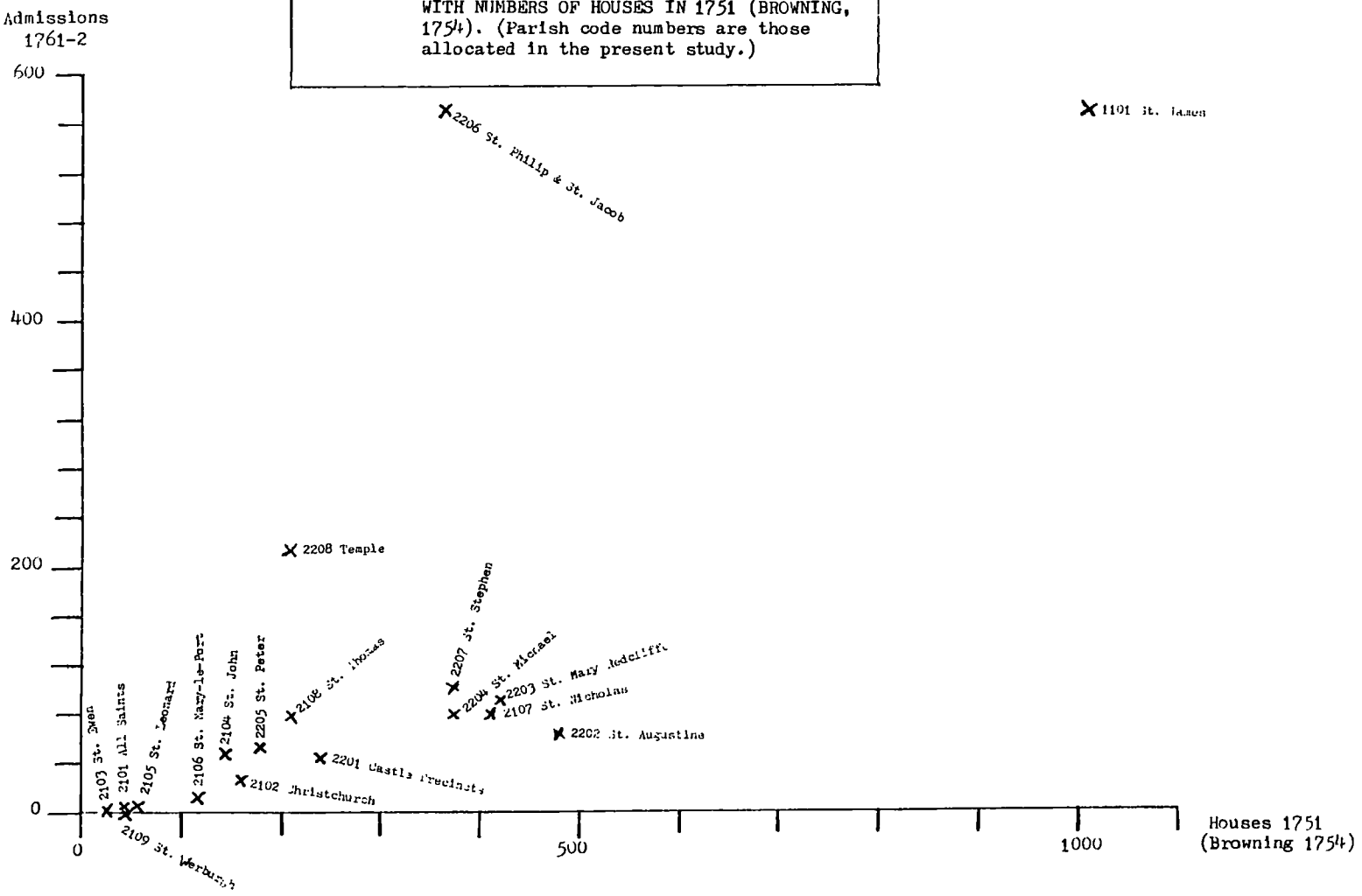


Fig. 1.4 OUT-PATIENT ADMISSIONS FROM CITY PARISHES TO BRISTOL INFIRMARY, 1761-2, COMPARED WITH NUMBERS OF HOUSES IN 1751 (BROWNING, 1754). (Parish code numbers are those allocated in the present study.)



housing stock would suggest. Temple and St. James, especially the former, also seem to send more patients than expected. However, the 10-year interval between Browning's work and that discussed here was a period when these three parishes in particular were growing very fast. Matthews makes this comment on the size of St. James parish:[68]

> The parish of St. James being very large, and the building rapidly increasing, the parochial Church had been long insufficient to contain the inhabitants; and an Act of Parliament was procured to divide the parish, and to erect a new parish Church, dedicated to St. Paul. This was founded April 1789.

A similar division had earlier taken place in 1751 in Sts. Philip and Jacob, thereby to create a new church in Kingswoood, dedicated to St. George.[69] It is therefore quite probable that the large number of patients from these three parishes reflects a big increase in the population of the parishes in the intervening ten years. Bristol as a whole was growing very fast and these parishes were growing especially fast. Clearly, there is therefore little point in statistical analysis of the relation between numbers of houses in 1751 and Infirmary admissions in 1761-2.

St. James was separated from all other parishes in coding used in this study because it was the parish of the Bristol Infirmary, but the Infirmary building itself is very much to one side of the parish and close to several inner and smaller parishes. Many people from outside St. James would therefore have been physically nearer to the Infirmary than some within the parish of St. James itself.

While it is also true that the central city parishes undoubtedly had the older and more crowded dwellings several of these parishes were very small in size, (see Map 2 in Appendix 2). Two further possibilities are also worth considering. First, the central areas may have had among their population more destitute, many of whom may have been looked after by the Corporation of the Poor, and

therefore may not have needed the Infirmary so much as would otherwise have been the case; and second, the well-built spacious districts at the periphery may be assumed to have had, serving the better-off population, a large number of domestic servants, artisans and minor tradesmen, many of whom would have been eligible for admission to the Bristol Infirmary by being classified as belonging to the `Laborious-Industrious Poor'.

While the housing data do not permit any positive conclusions, negatively there is no strong reason to suppose that patients from either the inner or outer city predominated over each other in proportion to the eligible population.

The most important conclusion to be drawn from this population study bears upon the part played by the Infirmary in the city's life. Of the 1015 In-patient admissions 746 were from inside the city, and of the 2385 Out-patient admissions, 2060 were of this origin. If there were 38,000 inhabitants, and if allowance is made for re-admissions, mainly transfers between In- and Out-patients, then in one year 7.4% of Bristolians were admitted to the Infirmary, nearly 2.0% as In-patients. The Infirmary was therefore a major civic institution - not a token charity just sufficient to palliate consciences.

1.8 THE BRISTOL CORPORATION OF THE POOR

The Bristol Infirmary, initiated in 1735 and opened in 1737, was not in its time the first or only publicly supported means of delivering free medical care locally. It was pre-dated by the Bristol Act 7 & 8 William III which inaugurated, in 1696, the Bristol Corporation of the Poor. As the city had developed and grown, the population of any one parish might tend towards being predominantly either rich or poor, with the consequence that the burden of maintaining the poor could become heaviest exactly where the ability to bear it was least affordable. The Bristol Act

embodied two main provisions, the establishment of a pauper manufactory (impossible for a single parish funding it alone) and the Corporation of the 17 parishes, with Castle Precincts as its eighteenth member, to form a single administrative unit for all matters relating to the employment and maintenance of the poor. Existing provision for the poor, such as outdoor relief, continued under the new administration. This Bristol Act was the country's first law uniting the parishes of a town in poor relief.

The documentation of the Corporation of the Poor has now become far scantier than that of the Infirmary for the same period. This is because the early, and most of the succeeding, records of the Corporation, which had been stored in St Peter's Hospital, were destroyed in the air raids on Bristol in 1940. Fortunately E.E. Butcher had made a detailed study of the records in the early 1930's,[70] a selection of which were published. Concerning the sick, Butcher records that a cripple was admitted in 1701 and a lunatic in 1707.[71] James Johnson quotes from a Minute Book of the period just prior to 1700 showing that 36 `impotent' were admitted within a three month period and that of the 36 so admitted 23 were aged over 70 years.[72] These and other admissions must be seen against the background of the original intention of the workhouse/manufactory as a place of education and discipline of children with the intended aim of ensuring their early and continuing self-support, as well as of succour for the destitute, the elderly and the insane.

It must be emphasised that the Corporation of the Poor has been examined in this present study only for the purpose of defining the position of Bristol Infirmary within the city and little or no attention is paid to the work of the Corporation of the Poor which does not show in some way a relationship to the purposes and work of the Infirmary.

Although the care of the sick was not the primary motive for instituting the Corporation of the Poor, that

such care was carried out in a continuing and formal manner is evident from a number of sources. In 1697 Dr. Thomas Dover (of `Dover's Powder' fame[73] and officer of the ship that rescued Alexander Selkirk, the original of Robinson Crusoe, from Juan Fernandez[74]) was engaged as the Corporation's first physician.[75] Dr. Dover neither expected nor received any payment and in this respect a foreshadowing of the honorary service of medical practitioners to the voluntary hospitals can be seen. Whether Dr. Dover offered his services out of concern for the paupers or as a stimulant to his paid practice is also uncertain but in this respect too there could be a foreshadowing of the practice of medical practitioners vis-a-vis the Infirmary, where a rise in prestige and social status would be the expected result of the services they offered voluntarily. Dr. Dover's make-up never included moderation, the lack of which was exhibited, perhaps, nowhere so flagrantly as in his free use of the metal mercury.[76] The first mention of `Chirugeons' as being employed at St Peter's Hospital dates from 1699[77] and apothecaries from 1717.[78]

Medical, like other poor relief was not restricted to inmates. To quote John Cary, the chief architect of the Bristol Act, in his defence of the working of the Corporation against criticism:[79]

> To such as were sick, we gave Warrants to our Physician to visit them; such as wanted the Assistance of our Surgeons were directed to them, and all were Relieved till they were able to work; by which means the Poor having been well attended, were set at work again, who by neglect might with their Families have been chargable to the Corporation.

The value to the rate-payers of the medical services of the Corporation of the Poor is here made evident. The reference to a pauper returning to work suggests that the Corporation of the Poor became responsible not only for those becoming sick while in its care, but those made into paupers by sickness. The care of the poor -

including the sick poor - was a legal obligation on the city, as was raising a rate for it. This raises the question of whether people, such as the Subscribers to the Infirmary a generation later, would prefer to give to a medical charity and so avoid a rise in rates, or would prefer an increase in rates payable by all eligible, to charity from a few.

A contemporary critique advocating a return to the unpooled parochial system of relief offers another side to the picture of outdoor medical relief. One reason advanced in this critique was that if every parish elected its own doctor to care for its own sick, then greater numbers of doctors would gain experience. Under the Corporation one doctor `now engrosses the Whole'. Those who supported the Corporation were advised to appreciate that `Raw Servants' were being used to carry out professional medical duties in the homes of the poor with results that could be seen all around, for `very rarely any Cure is made'. Any such experience thereby gained, when measured in terms of restored health to the poor, was very costly, even life-costing and if `the Young Men really improve themselves thereby, it may be said, That the Rich are Cur'd at the Expence of the Poor'[80]

In 1738 an Infirmary was added to St Peter's Hospital in which `pens' were erected for the secure and safe restraint of lunatics.[81] By the standards of the day the care given to these mentally disturbed patients was humane.[82]

> ...no iron chains, manacles, hand bolts, nor any other instruments, being permitted to be used; and when the individuals may be suffering under the highest state of mental excitement, confinement in the pens, application of strong leather straps for the arms, and the strait waistcoat, are the only means applied, and these are sufficient.

The same writer refers to Oldfield Lodge, a house in Milk Street, as being a receiving house for the sick

poor. The earliest use of this house is unknown but in 1743 the Guardians of the Corporation of the Poor determined to give it up. Notwithstanding this, it was still their property in 1798.[83]

> ...The Governor reported that these premises were for sale, and that the sum of £1000 was stated as the price: he also observed, that the medical gentlemen of the House had complained of the great distance of this building, and, that by the sick being removed into the Hospital, they did not consider that the health of the other inmates would be in the least injured thereby; that they would more readily attend the sick there, than when they were removed to so great a distance as Oldfield Lodge, in Milk Street.

Having in mind that the Bristol Infirmary began receiving patients in 1737[84] it can be appreciated that there was now, within the city of Bristol, medical provision for two socially different groups, one for the destitute and the other for those who, though not destitute still could not afford to finance their own medical care. It will be seen that these two channels of medical aid were distinct in function even if those using the services were occasionally admissible to either form of care.

1.9 THE INCEPTION OF THE INFIRMARY AND ITS ADMISSION POLICY

> For this last half year I have been working hard at a scheme which if I can bring it to bear will make a very great alteration in my way of living. It is to set up in this populous and rich city an Infirmary for sick and wounded by an annual subscription as is done at St. James', Westminster, and Hyde Park Corner and lately at Winchester.

The letter, addressed `John Orlebar, Esq., Hinwick by Wellingborough, Northamptonshire' and dated `Bristoll, December 11th. 1736', from which this quotation is taken was from Dr. Bonython of Bristol[85] whose public concern for the medical needs of the local poor had already received a good reception. An entry in the earliest Minutes

of the Bristol Infirmary and recorded by Munro Smith, confirms this.[86]

> A Subscription was open'd for Erecting an Infirmary in the City of Bristol for the relief of such Persons as should be judged proper objects of a Charity of that kind.

As we have shown, the need for a medical and surgical charity was not new and had in part already been met by the establishment of St Peter's Hospital. Nevertheless the main provision for care still arose from within the family, supplemented by resort to professional and amateur healers as need demanded and finance permitted. That there was no shortage of remedies for illnesses of every kind, real or suggested, is apparent from the plethora of advertisements carried in many of the local newspapers.[87]

However, the sick poor need not have been the only group to benefit by the setting up of the Infirmary. For the Subscribers it may have added a polish to their social status and for the medical staff wider and increased social contact with wealthy potential patients among the Subscribers.

By 1761 the Infirmary had existed for twenty-four years; it could have remained small though still big enough to give Subscribers a sense of doing good, but in fact it grew from a 34-bedded Infirmary at its inception to one of 132 beds by 1755. Notwithstanding, Bristol filled its Infirmary until it was bursting at the walls, with extra beds being put up in corridors and down the centre of the wards[88] - and then it boarded out excess patients.

At the interface of Bristol Infirmary's general policy with the public lies its admission policy, standing, as it does, between Subscriber and patient. It is where the two sides meet and therefore requires a detailed examination.

The central tenet of the admission policy is to be found in the Minutes of 22nd November, 1736 which confines admission to `such persons as should be judged proper objects of a charity of that kind'. The `proper object' status was the yardstick whereby all admissions were to be measured. To define a `proper object' required an economic judgement as well as a sound clinical one. In moral theory the Infirmary was for the `deserving poor', those described in the Minutes of 7th March, 1739 as the `Laborious-Industrious Poor'. `Deserve' here has the primary meaning of `have a rightful claim on'. This need not be due to moral virtue. The deserving poor are the poor whose need calls for help, those for whose condition help is appropriate. True, `deserving' can also mean `morally worthy of help', but not neccesarily so.

In no sense was there to be a cash transaction between the patient and the Infirmary. Referring specifically to Northampton Infirmary but embracing the whole `British Voluntary Hospital Movement' in the concept, Porter[89] writes

> For monetary payment would instantly have thrown the delicate boundaries between donor and donee into utter confusion, sullied grace with commerce, and destroyed the ritual of the gift relation upon which the whole superstructure depended.

The term `Laborious-Industrious Poor' implies not only an upper limit on patients' wealth but also suggests a base line above that of pauperdom. Tension was later to develop between the two instutions, the Bristol Infirmary and the Corporation of the Poor, over the alleged practice of the poor arriving in the city to take advantage of the services of the Infirmary, remaining after discharge only to become paupers and a drain upon the resources of the Corporation of the Poor. A copy of the letters exchanged are transcribed in the Minute Book under the date 1st September, 1752. Unlike the Corporation of the Poor, the Infirmary had no responsibility for a healed patient who then failed to obtain employment.

Perhaps it was those poor, coming in from outside the city, but who did not survive their stay in the Infirmary, who accounted in part for the cost of providing the funerals itemised in the yearly abstracts of accounts printed in the States (the Infirmary's annual published summary and report). Subscribers were supposed to deposit 12s 0d security money to defray the cost of removal or the burial of any nominee normally domiciled outside Bristol and on parish relief, but this may not always have happened.

No-one able to afford his own medicine was to be admitted to the Infirmary.[90] This criterion was used as an indicator, but medicaments were not, of course, the only therapy provided by the Infirmary. P.S Brown discusses the price of medicines advertised in Bath newspapers for the period 1744-1770 and shows that half of the 74 priced medicines most widely advertised cost from 1s 0d to 1s 9d,[91] approximately equal to a skilled man's day wages, at the values noted earlier in this chapter. The quantity of medicine purchasable at the prices quoted is unspecified but even so the true cost has to be seen against an insecure income which may often have left nothing over after paying for necessities. Bath is fourteen miles from Bristol and an examination of a sample of Bristol newspapers shows drug prices in a similar price range.[92]

Recommending admission was not open to those who could afford to be Subscribers but were not.

The 1758 Rule Book states[93]

> That every Subscriber be desired not to give a Recommendation for a Patient to any Person who asks it, when the Person requesting it is capable of subscribing himself.

Annual subscriptions were set in the 1758 Rules at £2.2.0d,[94] with life membership obtainable on a £31.10.0d. contribution.[95] Clearly anyone who could afford £2.2.0d per annum or a single payment of £31.10.0d should not batten on

his more generous fellow-citizens, but fortunes fluctuate. Being a Subscriber was, as it were, part of one's status, subscribing was not seen as an irregular or intermittent happening, and a Subscriber's name normally recurs through a long succession of years.

Residential qualifications, as initially proposed, were relaxed as the Infirmary increased in self-confidence. The 15th proposal of the first Minutes states[96]

> That no Person shall be admitted into the Infirmary as an In Patient or receive Medicine as an Out Patient who hath not been resident in the City of Bristol or the Out Parishes of St. James or St. Philip & Jacob for the space of Six Months before his or her admission. (except Mariners arriving in the Port, and also except the case of Casualties actually happening within the Liberties of the City, or the said Out Parishes).

This very restricted area was early extended to take in parishes adjacent to the city but it was not until 1743 that it was resolved `That all Persons, properly recommended be capable of being admitted, without Regard to their Place of Residence'.[97] This policy was reaffirmed in 1747 by the statement[98]

> This Charity is not confined to the City of Bristol, or even the Kingdom of Great Britain, but is designed to extend to all real objects from any Part of the World.

The reason for this change may have been due to the founders discovering an unexpected demand from outside the city. If we note the places of origin of the patients, we can see that less need have been spent on expansion had the intake been geographically restricted; for example, 26.5% of In-patients in the twelve months under study came from outside the city limits.[99] (Here is a clear difference between the Infirmary and the Corporation of the Poor.)

It was considered desirable that the patient should be clean on admission but the Trustees conceded that at times poverty precluded cleanliness and a Minute reads[100]

> That no patient be taken in till their clothes are well cleaned and when any of them are so poor that they cannot pay for it that the Visitors for the week do order the Matron to pay for doing it.

A week later a way to exclude the more offensively clothed was minuted.[101]

> The Society agree with the Resolution of the Committee of Fri. 29th Feb. touching patients coming to the Infirmary with their cloaths in an offensive condition, and that it be recommended to the Visitors of the week to give preference to the Laborious-Industrious Poor who are recommended.

These two quotations show that, contrary to Fissell's understanding of the situation,[102] the Infirmary is envisaged as serving a different social and economic class from those who received succour at St Peter's.[103] Those whose clothes could not be tolerated were candidates for public relief. Presumably the `Laborious-Industrious Poor' came cleaner. The change of emphasis from helping the dirty to be clean, to denying them equal right of admission, suggests that someone not at the first meeting spoke strongly at the next to obtain some retrospective effect. Note the words `give preference to' rather than, say, `admit only'; this is why some patients, as already mentioned, would have been admissible to either the Infirmary or the Corporation of the Poor. Nevertheless, `to give preference' explicitly distinguishes one from the other.

Admission to the Infirmary was to be on the written recommendation of a Subscriber, copies of the form on which the recommendation was to be made being available to all Subscribers. Having obtained the recommendation the patient proceeded as instructed.[104]

> That Persons properly recommended and qualified, be admitted every Monday and Thursday, from Twelve to One o'clock, and at no other Time, except upon

> sudden Emergency: And that Advice and Medicines be given to Out-Patients Tuesdays, Wednesdays, Fridays, and Saturdays, as the Physician shall appoint, and to Surgeons Out-Patients every Day, as occasion shall require.

The admission policy concerning specific conditions and excluded diseases can occasionally be inferred from internal evidence though most exclusions are spelt out in successive printings of the Rules. Exclusions included foul scorbutic ulcers of the leg in the elderly, venereal disease, fits, smallpox, itch and `other infectious distempers'. Neither were `Incurables' to be admitted. Presumably this prohibition covered both classes of `Incurables'; those who were suffering from a disease which had been categorised as `Incurable' and those other individuals whose diseases were not in general deemed `Incurable' but in whom physicians and surgeons judged treatment would be unable to help. With no certain cure on offer for many of the ailments which affected the populace, the Infirmary was not providing a comprehensive health service, but rather looked to succour, sustain and treat as many as possible of the acutely infirm capable of a good outcome with the available treatment. For this reason also, those in a moribund condition were denied admission. With certain exceptions children under the age of 7 years and maternity cases were also not to be recommended. Although no written Rule excludes the admission of the aged *per se* only 9 In-patients over the age of 70 years were admitted in this period. (This age factor is in direct contrast with the intake at St. Peter's Hospital.)

The foul scorbutic ulcer of the leg was almost certainly a varicose ulcer, the healing of which was made more difficult by the underlying scurvy which the name implies, although the term `scurvy' was then less precise and the condition of that name was already yielding to treatment. (That is to say, `scurvy' had two meanings at this period: first, the disease called scurvy, and secondly, as an adjective for various conditions of the skin.) Long-

standing varicose ulcers require frequent dressings and give off a fetid, stinking odour. Nevertheless ulcers of the leg were among the distempers frequently appearing in the registers: 124 In-patients and 86 Out-patients in one year (See Chapter 4).

Bristol, being a port, venereal disease was probably particularly rife, presenting a public health problem. It was also known that sufferers were often unable to bear or beget children. At a time of perceived underpopulation procreativity was at a premium as was the potential good health of its future citizens. Notwithstanding, to admit and treat such cases might appear to condone, perhaps even support, immorality. While individual Subscribers may have been prepared to recommend particular sufferers, the effect on church collections and benefactions could, possibly, be deleterious. That the disease was God's judgement may not have been doubted by some even if it may have been judgement on a sliding scale, with an inverse relationship to one's social standing! (A comparison with modern attitudes to AIDS is not inappropriate here.) The Rules were explicit.[105]

> That no Person justly suspected by the Physician or Surgeon of the Week, to have the Venereal Disease...be admitted into the Infirmary on any Account whatever.

Regardless of this prohibition there must have been incentives to admit such patients; the treatment was well known, it would have perhaps cleared the area for a while of certain well known local women and a fatal outcome rarely terminated the hospital stay (none at all in the twelve months under study). The strength of this Rule had became eroded by 1779 when the clause `unless in such extraordinary or particular Cases as shall be approved of by them' (the physicians or surgeons) was inserted. We know that in his private practice John Townsend, surgeon to the Infirmary from 1755 to 1780 treated this condition, for

Richard Smith's *Biographical Memoirs* records of this practitioner,[106]

> He resided in Broad Street, having a side door inCider [sic] house passage. This was in his early time, and for some years afterwards, a great desideratum, as all syphilitic patients were in the habit of sneaking into a Surgery after dark privately, and the greatest care was taken to conceal them.

It is unlikely that such privacy would have been afforded the 40 Infirmary In-patients or the 30 Out-patients admitted with this infection during the period 1761-2.

As for admitting epileptic patients, the real problem was one of management, both of the patient and any who might witness the sufferer's violent behaviour during a fit and be frightened by it. A fuller explanation is given in the records of the London Hospital in this period.[107]

> It having been found by daily Experience that patients troubled with Fits are a cause of a great deal of Inconvenience in the House, not only by frightening into the same Distemper some who were never subject to it before, but also by frequently occasioning a Relapse to such as were almost cured, and as they can be treated as out-patients, Ordered to be treated as such.

No doubt other hospital authorities concurred.

This report uses `epilepsy' more widely perhaps than we should now and recognizes the contagiousness of behavioural abnormality in a closed society.

Smallpox was an endemic disease of the 18th century and was one of those, fewer than now, to be recognized as infectious. Because of the disease's known virulence it was the Infirmary's strict policy never to admit a case.[108] In 1779 when the Rules were updated and reprinted, and possibly wih hindsight, the Infirmary officers ruled that any patient who began to manifest the

disease during his stay as an In-patient should be removed from the hospital.[109]

> That all In-Patients who are attacked in the Infirmary with the Small-pox, be instantly removed from it, to proper Lodgings provided by the Matron, and that their respective Physicians, and in their Absence, some other Physician belonging to the House, visit and Care of them, and that all such Patients be supported during such Illness at the Expence of the Society.

`Itch' (scabies, as it is now more commonly called) is a skin infection spread by direct bodily contact. The condition is often a disease of neglect and poverty and flourishes in crowded, dirty environments. The causative organism, the parasitic mite *Sarcoptes scabiei*, burrows in the outermost layer of the epidermis and after a period of about three months causes intractable itching, the consequent scratching leading to extensive excoriation of the skin and secondary sepsis. In the time with which this study is concerned it was believed that the condition could be transmitted via infected bedding and it was probably for this reason that it was banned from the Infirmary.

Viewed overall, the admission of patients with infectious distempers posed the problem of containment. Many conditions now recognized as infectious, pulmonary consumption for example, were then not viewed as such, nor was the mode of origin and transmission of those recognized as infectious always fully understood. Preventive measures were therefore not fully implementable even if facilities had allowed. This was an insoluble problem in every hospital and must in all probability have resulted in the exclusion of many acceptably safe patients and the admission of many, possibly more, unsuspectedly dangerous ones. The Rules are uncompromising in this matter, as in other matters, but (as the Admission Register shows) their bark was worse than their bite!

As for the exclusion of children, their liability to succumb to opportunistic infections may have been

recognized even then and their unsuitability for nursing in a hospital environment acknowledged. It certainly would not have made economical sense to admit them. Children did not occupy a high place in society and though, when ill, may have been tended with care and affection by the family, it is unlikely that much public money would have been laid out on their medical treatment. A better use of resources could be made by returning the wage-earner to work. Under-sevens were therefore only accepted in very special circumstances, for example, young children suffering from the very painful condition of bladder stone.[110] There could also have been a societal reason for their exclusion. Children were properly the responsibility of parents. Removing them from parental control during periods of sickness could undermine such responsibility and at a time when great numbers of children were parentless any further erosion of family life sought to be avoided. Perhaps even then it was considered to be unnatural to separate small children from parents, unless fully fostered.

One group of children, though, did have special claim on the Infirmary, that is, those from Mr. Elbridge's Charity School.[111] Elbridge was a generous and rich Bristolian who spent £1,500 of his own money on supporting and furnishing the Infirmary during its first two years alone.[112] In addition, an entry in the Legacy Book records that a bequest of £5,000 was to be given to the Infirmary upon his death, a sum which was paid into the accounts on 22nd April, 1742. Earlier, Mr Elbridge had built and endowed a residential charity school for twentyfour girls in the grounds of his own home. With the only formality being a signed request from the Master, any pupil of this school could be accepted as an In-patient. In this situation admission was seen both as a benefit and special favour to the (presumably orphan) girls, and an *ex gratia* acknowledment of the debt the Infirmary owed to their greatest benefactor.

Fissell adds to these Rules one which did not exist, namely, that the Infirmary would not take the servants of the Subscribers.[113] She may have taken this Rule from Edinburgh Infirmary where special arrangements for payment were made,[114] or from the Rules of yet another hospital.

This list of exclusions worried some associated with the Infirmary. In his Anniversary Sermon preached in 1743 the Revd. John Castelman made a plea for[115]

> ...a Ward for Incurables; and a Ward for a Multitude of Women in Travail, destitute of every thing, not convenient only, but necessary too.

Castelman's plea remained unanswered for some time. Perhaps it was addressed to the wrong body. Not only was the Bristol Infirmary not the place for those `destitute of every thing not convenient only' but `pregnancy' and `labour' are not the names of diseases. However, a Bristol Lying-in-Hospital was founded four years later, in 1747, and in 1771 help was to be forthcoming for `Incurables' through the beneficence of Mrs. Mary Innys[116] (as will be noted later in this chapter). These exclusions may have been hard for those kept out but they did spawn the specialist hospitals of a later generation. Maternity hospitals, fever hospitals, lock hospitals, tuberculosis sanatoria and childrens' hospitals were not far behind the general Infirmaries.

The intention that the Infirmary should be a hospital for acute conditions, responsive to therapy, is given further support in the Rule limiting length of stay.[117] Fig. 1.5, p.57, sets out in histogram form the length of stay of In-patients, and shows a particularly marked difference between the number of patients discharged in their 13th week of stay as compared to either the 12th or 14th week of stay.

> That Persons admitted into the House, and in three Months receiving no Benefit, be discharged, unless

> the Physician or Surgeon, under whose Care they are, desire they may be continued.

There is no evidence that length of stay could be affected by the letter of recommendation, nor do the Rules and printed form of application provide for it. However, Fissell writes:[118]

> The urban worker might also try to get a recommendation for a lengthy stay in the infirmary, or the equivalent of out-relief in the outpatient department of the hospital or a dispensary.

W.B. Howie, writing of the early days of the Royal Salop Infirmary, shows us that seeking a stay for residential purposes was a ploy not unrecognised by hospital Subscribers.[119]

> `Subscribers were warned against supplying recommendatory letters to known `regulars' with chronic complaints who made a habit of looking around for some sympathetic person whom they could persuade to send them into hospital when the cold winter weather set in.

Fissell cites no source for her statement but it will be seen from Fig. 1.5 that actual lengths of stay were compatible with the Rules, while the only form of `out-relief' available was attendance as an Out-patient and the provision of medicines. In this study no provision for such a recommendation, or evidence of its exercise, has been found.

So the Infirmary was what we should now call an acute hospital, a place of care and cure, not somewhere to languish, somewhere to die. There was an unmet demand on the available beds from those who could be helped without admitting those who were past assistance, although the register does show that moribund accident victims arriving in the crisis of a surgical emergency were admitted, presumably either on humanitarian grounds or because the extent and effect of their injuries had been underestimated.

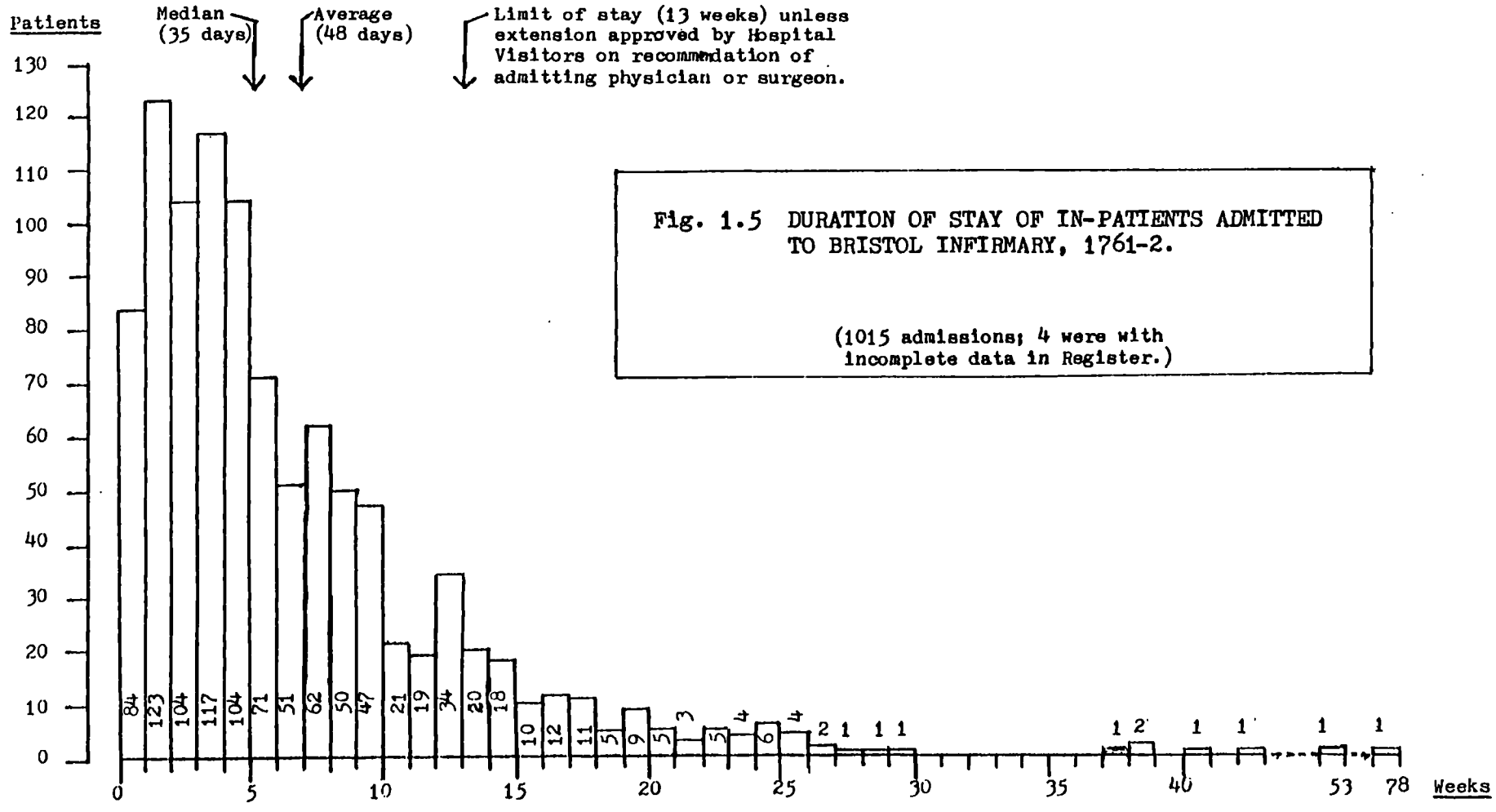


Fig. 1.5 DURATION OF STAY OF IN-PATIENTS ADMITTED TO BRISTOL INFIRMARY, 1761-2.

(1015 admissions; 4 were with incomplete data in Register.)

It was hospital policy to care for the `labouring poor', to return them to health, and to launch them back into the labour force with the minimum of delay. (The Corporation of the Poor, by contrast, had to care for those in its continuing charge, dealing with sickness as necessary; it could not therefore have restricted its medical care to those whose diseases were acute.)

It can be seen that, as far as medical conditions are concerned, the admissions policy was not capricious. Patients who could not be `Cured', or at least `Relieved', were not wanted; those who might cause the spread of disease or were prone to infection were to be avoided, and those whose behaviour through the manifestation of epilepsy was unpredictable, unwelcome, while the moral undertones of venereal disease have already been noted. Even with all these exclusions there was still considerable overcrowding. In 1755 the bed complement had been raised to 74 for males and 58 for females but even so extra beds frequently had to be erected in passages and down the centre of the wards as already noted, an expedient still all too frequently necessary.

The total number of In-patient bed weeks for the year under investigation equalled 7,225 and corresponds to 139 equivalents of beds with a 100% occupancy. An 85% bed occupancy was the desired level in the National Health Service of the 1980's with 82% achieved by the Bristol Royal Infirmary in 1988/9.[120] (Queen Victoria gave permission for the Bristol Infirmary to be re-named the Bristol Royal Infirmary in 1850,)[121] As the beds available numbered 132 the over-subscribed bed-equivalent, plus inevitable occasional vacancies, are explainable only by the sharing of beds, by putting up extra beds, or by boarding out. Even so, the Hospital State for 1762 carried the usual standard paragraph, with only the current figures updated.

> Though the Number of IN-PATIENTS of this Year amount to 1157, yet we have been obliged, for Want of Room, or because they were not proper Objects

of the Charity, according to our Rules to refuse 386 who have been regularly recommended.

The Infirmary staff were not sanguine about this state of affairs. In the 1779 Rule Book, (and the full title of the Rule Books makes it clear that all newly revised Rule Books were to make *de jure* what what was already custom) the following addition makes its first appearance.[122]

> That such Patients as are proper Objects, and shall be excluded at any Time for Want of Room, shall be entered in a Book kept for that Purpose, and be preferr'd on the ensuing Admission-Day to any other Person in similar Circumstances.

We know that boarding out was one means used to extend the service and a standard paragraph in the 1762 State reads,[123]

> As there have been for the whole Year at least 132 In-Patients constantly in the House, this Want of Room must be imputed to the Increase of the Number of Persons recommended, and the Number of Casualties, which require immediate Admittance, of which there has been this Year 163, to provide for which we have been obliged to lodge several of those In-Patients, who were judg'd best able to bear it, in the Neighbourhood, at the Expence of the Society.

And then to keep the Subscribers happy is another standard paragraph.

> This, we imagine, will satisfy those Subscribers, whose Recommendations have not been comply'd with, that Necessity was the only Occasion of their being refus'd.

At least, now we know how Casualties could be accommodated in a hospital already bursting at the seams. This pushing of convalescent patients out into lodgings was not the Infirmary providing a domiciliary service for the poor. It was paying for the patient to have relief, not for the patient to have a home. Medical care by the same Infirmary staff would still be continued and the Rule

limiting stay still applied. This system of hospital management is still in use, though now in the guise of convalescent homes, but not as widely so as even 25 years ago. (Now, further savings can be made by discharging patients early and if, as a result of a too-early discharge, re-admission is required this is seen as an increase in the `through-put' of patients, showing that the hospital is, managerially speaking, more efficient.)

Urinary disorders were an early specialization at the Bristol Infirmary, particularly when bladder calculi (stone-like concretions) were present. In Munro Smith's prosopography of Dr Middleton, one of the Infirmary's earliest physicians, Dr Middleton's name is linked with those of five other Infirmary medical men as practitioners in the procedure of lithotomy.[124]

> Dr. Middleton wrote a short essay on the operation of Lithotomy (i.e. the removal of urinary calculi), a surgical procedure which Castelman, Thornhill, James Ford, and the Pages became rather famous for in the early days of the Infirmary.[125]

In the first three years of the Infirmary's history 16 males underwent this operation, usually with good result,s[126] and 5 patients with calculi and 3 with gravel (the precursor of calculi, for gravel provides the nuclei for larger calculi to form) were admitted during the twelve months of the present study, all 5 with calculi undertaking considerable journeys in order to be admitted. Travel with this condition could be particularly painful, though for these sufferers apparently preferable to retaining the stone. That so few local cases were admitted may be due to the fact that 41 locals were treated for the pre-condition of gravel on an Out-patient basis. All but 3 of these patients were discharged as `Cured'. The availability of early treatment appears to have been taken advantage of and with a high success rate resulting. As for nursing care, a large garret within the Infirmary was set aside for the sole use of these patients and here, for those who could bring help, private nurses were allowed.[127]

Unlike the Edinburgh Infirmary,[128] medical teaching at Bristol was not one of its prime purposes. (The Bristol Medical School[129] was opened in 1833.) However, Bristol surgeons did have private pupils who resided with them and assisted in their practice. This was allowed for under Infirmary Rules.[130]

> That each Surgeon be allowed to bring his Apprentices to assist him, and each two Pupils, and no more at one Time, to be instructed in Surgery, and that they be allowed to take Money from their Pupils for such Opportunity of Instruction.

In addition to providing a considerable source of extra income, apprentices enhanced the prestige of the surgeon among both his peers and his patients. The need for a student to be exposed to as wide a variety of medical conditions as possible may have been an additional motive underlying the broadness of this particular Rule.

In certain limited areas the agreed admission policy appears to have been ignored. In the twelve month period under study 28 males and 12 females were admitted with venereal disease. It is also true to say that 4 out of a total of 6 patients, found after admission to have been admitted `Irregularly', (that is, in contravention of the Rules,) were subsequently discharged as `Against Rules', because they were suffering from venereal infection.[131]

There were no cases of foul scorbutic ulcers in the elderly; the 4 patients suffering from itch all had other conditions which in themselves could warrant admission and the same observation can be made of the 2 patients admitted with fits. Certainly no case of smallpox was admitted although 8 did contract the disease during their In-patient stay. True, a number of patients with other infectious diseases were admitted but this was probably more a lack of understanding of the transmission of disease than a flagrant breach of the Rules.

It is unlikely that many who died shortly after admission were recognized to be in a dying state although 24 of the 86 deaths did occur in the first week of stay. As the Infirmary was intended to aid the cure of distempers, it would not have been helpful for it to be known as a place of death, nor was the deliberately undertaken care of the dying within its declared scope.

In 1761-2, of the 78 patients discharged as `Relieved', that is, improved but not `Cured', only 5 had been in for a week or less and 26 went on to become `overtime' patients.[132] While most of these 26 patients had conditions which possessed a tendency to become chronic afflictions, it may well have been the case that the individual patient was just not yet ready on medical grounds for discharge and that a complete cure was indeed hoped for. There is no evidence that extended stays were allowed on purely social grounds.

Fissell argues the point that it was, in many cases, family circumstances which influenced an individual's length of stay and not only their medical condition.[133]

> For people with contusions, family connections exerted a strong influence on hospital stay. Single adults stayed almost four times as long as those who were married and had a family, and twice as long as adults without an identifiable family. Similarly, old people without connections spent, on average, 10 days more in hospital than their counterparts with local kin. The same pattern can be seen in old people with ulcers, whose time in hospital was also framed by the availability of domestic care.

From this, Fissell argues that the Bristol Infirmary added sheltered accomodation to their curing provision.[134] Of course, as noted in the review of the published work in the Introduction, the point in convalescence at which a patient goes home does in part depend upon home conditions and care available, especially so if dressings are required but the discharge date is for this very reason a medical consideration. This is still

true and applies to rich and poor alike. Time of discharge can be totally unrelated to non-medical functions of the hospital. Doctors still have to consider home conditions when recommending the optimum time for discharge during recovery; it is a medical decision, taken on medical grounds, even if affected by the pressures of warfare or government funding policy, and socially convenient prolongation of stay is especially improbable in an acute hospital with patients queuing for admission.

There were 9 patients discharged as `Incurable', amongst them being one of the shortest-staying patients, a twentyone year old man whose diagnosis was `Pupils of both Eyes destroyed by lightning',[135] and one of the longest-staying patients, a young fourteen year old girl who had an even more unhappy prospect, for her diagnosis was `Cancer of the Nose & Palate with a fistula lacherymalis [sic] in each Eye'.[136]

While it is true that 11 under-sevens were admitted, 6 of these came as Casualties. No parturient woman entered and there were only 3 post-delivery cases, 2 with puerperal fever and 1 `hurt in Lyeing in'.[137]

1.10 RESTRICTIONS ON ADMISSION

Taken together these records would suggest that the `House Visitors' who were charged with examining `...all Persons offering themselves for Patients and certify[ing] that they are qualified according to the Rules of the Society' were carrying out their duties effectively and to the best of their knowledge. (The term `House Visitor' was applied to those Subscribers whose duty it was, during that quarter, to oversee the admission of patients, to inspect the food and listen to any complaints In-patients may express.)[138] What effect on prospective patients would this admission policy be likely to have? What effect would such an admission policy have on those whom it excluded? Langdon-Davies appreciated this problem.[139]

> When the initial efforts of the founders of Westminster Hospital began to have practical results, they soon found that although they were certainly able to help a number of people in a small way they were forced by their limited resources to do nothing for many others who needed help in other ways. The very act of being charitable involved the risk of acting uncharitably in some other way which had hitherto escaped notice.

But he could not resolve it.[140]

> The pioneers in charity were now forced into the position of condemning neighbours to death. No blame attached to them: they could not do otherwise and foster the resources needed to build up a hospital.

It is the old story of limited resources. (cf. George Bernard Shaw - *The Doctor's Dilemma*.)[141]

It is a matter of perspective whether the Infirmary is viewed as an institution which fills a gap or an institution which makes a space for itself. This work seeks to indicate the former rather than the latter and sees the Infirmary as filling a therapeutic gap, providing acute treatment for acute diseases. While not proving a panacea for all ill-health it was certainly effective in reducing, however slightly or greatly, the pool of ill-health (Chapter 5). As for those sick people specifically excluded under the Rules, their physical condition would not have been worsened by the advent of the Infirmary though they could perhaps have suffered from a sense of discrimination, arguably on limited explanations of personal fault. (These exclusions were to foster a spread of charitable endeavour in future generations, for example, children's hospitals, hospitals for the incurable, and 'fever' hospitals.) However, should there be another sick family member who could be assisted at the Infirmary, relief from medical expenses and a quicker return to the restoration of a household income could have left more of the household's resources available for those excluded from the Infirmary.

In this sense, the excluded would also have been beneficiaries.

Many who were `proper objects' of the charity might perhaps have had cause to be thankful for the wide exclusion clauses, for these channelled to their care more resources than otherwise would have been available and made for a speedier restoration of household income to the `Laborious-Industrious Poor'.

As noted earlier, after 1771 there was some help available for patients whom the Infirmary had to discharge as `Incurable'. In that year a bequest of £500 was received by the Infirmary from the executors of Mrs Mary Innys's estate, together with the interest from a further £500[142]

> for the better and more comfortable support of such unhappy Persons as shall be discharged from the said Infirmary as Incurable,

though cannily she adds,

> But I do declare that I do not mean hereby to ease the respective Parishes to which such Persons may belong from the Burthen of their Maintainance, but to add thereto, that they may be more comfortably supported in their Distress.

Mary Innys was concerned that her benefaction should be in addition to and not part of the obligations of parishes to care for their own needy. It was not, for instance, to be perceived as an alternative to care, rightly the responsibility of the Corporation of the Poor, or as an opportunity to reduce the Poor Rate. The parallel in today's conditions would be that Mary Innys would not wish her benefaction to be used for the purchase of essential items of equipment in the National Health Service but rather to provide after-care and non-medical support.

As the admission policy placed restrictions on the patients to be admitted so it placed other restrictions on the Subscribers.[143]

> That no Trustee have more than one In-Patient at a Time, except in Case of Casualties; nor more than Three Out-Patients at one Time on the Books.

This was a restriction that was not always observed. It could perhaps be that for some patients, arriving at the Infirmary at admitting times without a recommendation but requiring immediate attention, the recommendation form was signed by one of the House Visitors in attendance, regardless of whether he, the House Visitor, already had a patient in residence. It could also be that it was no-one's business to check if the nominating Subscriber was responsible for a current In-patient or, maybe, the Subscriber was genuinely unaware if a previous nominee had, or had not, yet been discharged. These remarks are, however, speculations.

It can be seen, then, that the constitution of the Infirmary required a policy that was acceptable to its present Subscribers and encouraging to prospective ones. It would therefore have to be at some pains to demonstrate the worthwhileness, even the morality, of its activities. Clear boundaries would need to be obvious, enclosing those groups considered deserving of admission while excluding certain others.

1.11 COMPARISON OF THE PROVISION OF CARE FOR THE SICK POOR AT BRISTOL INFIRMARY AND BY THE CORPORATION OF THE POOR

It is now possible to note differences between the Infirmary and the sickness services of the Corporation of the Poor. It will be seen from what has been written already in this chapter that the Infirmary did not originate in the workhouse or from it.[144] It may be worth reminding ourselves that the Bristol workhouse was set up by statute while the Infirmary was an independent voluntary organization. To what extent the function of the Corporation of the Poor and the Infirmary overlapped or were

distinct will become further apparent in subsequent chapters. However, neither originated in the other. The earlier left a space which the other filled, that is the medical care of those not poor enough to be the proper concern of the Corporation of the Poor yet too poor to afford their own medicines.

In considering the distinction between the Corporation of the Poor and Bristol Infirmary cognizance must be taken of the ideas of `incarceration' and `moral reform', already referred to in the Introduction. Fissell states that `Medical men's power over their patient's bodies depended upon incarceration'.[145] There is no evidence whatever adduced by Fissell or found during the present study, that any person was forced to enter the Infirmary or was, alternatively, prevented from discharging himself from it. Indeed, 33 patients in this twelve months study are recorded as leaving by their `Own Request'. By contrast, forced incarceration within St. Peter's Hospital, the residential arm of the Corporation of the Poor, was often imposed by the law.[146]

With reference to moral reform, attention in the Introduction has been drawn to Alured Clarke's notion of using a hospital to keep the patient away from morally undesirable influences. No such idea is recorded in the documents of the Infirmary or expressed by its founders.

Fissell, though, writes:[147] `One of the most apparent features of charity and poor relief in eighteenth-century Bristol was its commitment to moral reform'. Moral reform may have been one apparent feature of the Infirmary but it was not its prime purpose; that purpose was medical and surgical care. It may be worth noting that even Tucker, the most ardent and ferocious believer in the use of the Infirmary for moral reform, considered healing its primary purpose.[148]

The relation of the Infirmary to the Corporation of the Poor may now be summarised as follows.

The Corporation was a statutory body maintained by a legally enforcable levy (poor rates), while the Infirmary was an independent society maintained by voluntary contributions. The Corporation was concerned with paupers while the Infirmary gave priority of admission to the`Laborious-Industrious Poor', those whose poverty was that of low or irregular wages. Since lack of priority is not exclusion, a pauper might be admitted to the Infirmary. Conversely, a usually-employed worker rendered unemployed and penniless by sickness might be cared for by the Corporation. Nevertheless, the Infirmary's priority is explicit. While the Corporation would have given medical or surgical help only when destitution was already a fact (irrespective of immediate increase of impoverishment, if any), an Infirmary patient might be admitted directly from wage-earning, with expected return thereto. Therefore the regular earnings of a breadwinner would not have excluded admission of a dependant to the Infirmary, provided that the household was poor enough.

Insofar as the purposes of the Corporation might have included economic advantage to the rate-payers, the advantage sought would have been to make paupers productive. Insofar as the purposes of the Infirmary might have included economic advantage to the social classes from which the Subscribers came, the advantage sought would have been to return to full productivity those whose already productive life had been affected by sickness or injury.

The Corporation was concerned with changing the mode of living (`reform of manners') by, for instance, occupational training, with healing services additional to this, while the primary concern of the Infirmary, in both theory and practice, was treating the sick and injured. Neither was there any legal provision for assigning to the Infirmary, or detaining there, any person. The

Corporation's Workhouse, on the other hand, was a place to which one might legally be sent or taken.

The Corporation provided domiciliary visiting by a physician, as well as hospital care. The Infirmary had no domiciliary service but, on the other hand, it treated Out-patients and dispensed free medicines. In the nature of the Corporation it would have been bound to care for chronically sick paupers, and did so, while the Infirmary was a hospital for acute conditions only. After 1743 the Infirmary, unlike the Corporation, admitted irrespective of the patient's place of home or origin. At times this could cause the distinction between the institutions to be manifested by one becoming irksome to the other (see p.46).

1.12 CONTINUITY AND CHANGE : THE BRISTOL ROYAL INFIRMARY IN THE 1990's

In general terms the Bristol Infirmary's policy has changed little between 1761 and 1991. The emphasis on acute disease remains although the 13-week limit of stay does not. Paediatrics and obstetrics remain the concern of others, and most infectious diseases are outside the Infirmary's field of activity. Venereal diseases have gained the attention *de jure* that they were already receiving *de facto* in 1761. In 1991, however, Bristol Royal Infirmary took trust status during the re-arrangement of the National Health Service, opening up the possibility of a new policy, based on the marketing of services. Since the price which hospital care commands on the market is not proportionate to the cost of providing it, and since some diseases are therefore more profitable than others, the Infirmary's long-standing policy is likely to be influenced by switching resources from less profitable to more profitable groups of patients. (The new policy distinguishes among acute conditions.) So ends, perhaps only temporarily, a policy of two and a half centuries.

CHAPTER 2

The exercising of power : Subscribers and their control of admissions and finances.

2.1 INTRODUCTION

It is appropriate in this chapter to examine the ways in which Subscribers (also called Governors) exercised their authority within the Infirmary, which will be seen to be primarily by their control of admissions and handling of the finances. In considering the Subscribers note is taken of their numbers, and of their religious denominations, political allegiance and other social connections. Subscribers' behaviour in recommending prospective patients for admission will also be discussed.

As an approach to the power exercised by the Subscribers through contol of the Infirmary's money, the management of income and expenditure for 1761 and 1762 is here considered with some particularity.

On the patients' side, control of admission is reflected by the method of obtaining admission, either as a Casualty (for which no Subscriber's recommendation was needed) or through a Subscriber's letter of nomination. The places of origin of patients, with special attention to differences in distemper between those of far and near origin will also be considered.

2.2 SUBSCRIBERS AND ADMISSIONS

The Hospital State for 1761 lists 459 names of Subscribers to the Bristol Infimrary with an additional 29 life members and 2 regularly donating corporate bodies. The following year's Hospital State lists 471 Subscribers; the number of life members and corporate bodies remaining unchanged. To these numbers we have added the names entered in the Subscription Book but who do not appear in either of the two

States. Over the two years personnel changed, some old names dropped out and some new ones arrived. All Subscribers had equal rights, rights exercisable six months after the receipt by the Infirmary of their subscription[1] and all Subscribers were desired to take an active part in the management of the Infirmary through the role of House Visitor.[2] (Although there were a number of female Subscribers no female appears to have acted as House Visitor.) The term `Subscriber' was synonymous with that of `Governor', `Trustee' or `House Visitor' and the term used in any particular context varied according to the occasion.

A study of the combined 1761 and 1762 Subscription lists reveals a body of 570 supporters, 73 of whom were female.[3] Included among this body were the Mayor and Common Council (corporately), the Society of Merchant Venturers, 3 private companies and 30 life members. (Support from the Common Council and the Merchant Venturers was additional to any support given by individual members on their own account). During the twelve months under investigation 461 Subscribers successfully exercised their right to recommend patients for admission. A variety of sources have been explored to identify and categorize as many Subscribers as possible and so to flesh out the bare bones of names in the subscription lists.[4]

In the case of Bristol it is not true that the aristocracy or landed class were particularly supportive of the Infirmary either at its inception or in its continuation. In this matter it does not support the view of Porter[5] that `the landed classes were indeed prominent in all the stages of seeding the infirmaries' but reinforces the findings of Owen[6] who writes `donors came overwhelmingly from trade and commerce rather than from the great families'. The first subscription list indicates, by title, only one baronet and two members of the higher clergy.[7] The largest and truly enormous sum of £5,000 was a posthumous gift from John Elbridge who, though distantly associated by marriage with the aristocracy, had no lineal connection with

it. Bristol Infirmary may have wished that it shared the type of support given to St. George's Hospital which, as Woodward[8] points out, probably had the most aristocratic sponsorship of all Infirmaries. (Poached from Westminster Hospital following their seccession from that institution in 1733?) However, this lack of support from `outsiders' does allow Bristol Infirmary to be seen as a truly `citizen' hospital and to profit by its close ties to the city and its new bourgeoisie.

An annual subscription of 2 guineas or a single payment of 30 guineas secured nomination rights up to a maximum of 1 In-patient and 3 Out-patients concurrently.[9] Participation in the Infirmary's administration through activity as a House Visitor and power to elect medical staff could either be viewed as an additional inducement to subscribe or a responsibility which could be avoided. But there would have been privileges which came without a downside: the social advantage of being counted among those who subscribed, of widened social and business contacts, and the subtle advantage of being recognized at Infirmary functions. Thus, for an annual payment of only 2 guineas (and there were 402 2-guinea Subscribers in 1761 and 414 in 1762) the Subscriber could serve God and his own best interests. Subscription rates were set low enough to give the Infirmary a wide financial base but high enough to afford it some exclusivity, yet at a level that would be the most likely to achieve financial stability. Roy Porter discusses the need for this wide base when he writes,[10]

> It was essential to the wider social purposes of the infirmary that a broad social spectrum should be encouraged to give; the more donors, the more the community consensus, and the healthier the revenues.

Those Subscribers who exercised their right to admit patients got value for money. The cost of treatment, particularly In-patient treatment, often far exceeded the income derived from the particular nominator.[11] Two cases are used here to illustrate the point but these two are

pertinent to many. For his 2 guineas Mr. Worthington Brice[12] recommended 4 In-patients and 22 Out-patients. The cumulative In-patient stay extended to 201 days. Mr. Edward Lloyd[13] was able to nominate 4 In-patients and 17 Out-patients with a cumulative In-patient stay of 209 days. (See p.98 for costs) As noted already, the Infirmary provided 48,518 bed-days in the year.

Before studying the Subscribers some mention must be made of the small number of people who nominated patients but for whom no evidence of a subscription has been found. Of these, the 31 names identified for the year under study, (5 females and 26 males,) were responsible for 5 In-patient and 36 Out-patient referrals. Of the 5 females, 4 had spouses who subscribed. Of the remaining 27 nominees 19 had surnames which do appear in the subscription lists. All 23 of these recommenders with surnames shared by other Subscribers have been presumed to be functioning as Subscribers on behalf of another family member. No Infirmary connection can be found for the remaining 8 who between them were responsible for only 1 In-patient and 8 Out-patient admissions. Because of doubts as to the strict accuracy of the Hospital States which list Subscribers it has been felt acceptable to include all these 31 nominators in the following analysis of Subscriber profiles.[14]

Not all Subscribers were active in recommending patients. In the twelve months being reviewed 19.3% did not admit any patient, with female Subscribers being less likely to exert their rights than their male counterparts. Only 72.6% of female Subscribers admitted patients as compared with 81.9% of males. As will be shown immediately, when females did admit they were more likely, proportionately, to admit female patients than were male Subscribers. These figures may reflect the employment experience of females, pointing to the possibility that female Subscribers might have nominated their female house servants.

Female Subscribers were responsible for 75 In-patient admissions and 220 Out-patient ones; 8.6%[15] and 9.2% of the totals respectively. As a percentage of all patients admitted these 295 persons accounted for 9% of admissions, (again excluding Casualties) at a time when female Subscribers accounted for 12.8% of the subscribing body. Fig. 2.1 below sets out the actual numbers and percentages of In- and Out-patients by sex as admitted by female and male Subscribers.

Fig. 2.1 NUMBERS OF ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, BY SEX OF ADMITTING SUBSCRIBER AND SEX OF PATIENT

	IN-PATIENTS		OUT- PATIENTS	
	FEMALE	MALE	FEMALE	MALE
FEMALE SUBSCRIBERS (53, i.e. 11.5%)	38	37	138	82
MALE SUBSCRIBERS (408, i.e. 88.5%)	349	451	1162	1005
TOTALS	387	488	1300	1087

The most striking feature of the Table is the larger number of female than male Out-patients admitted by female subscribers. The tendency to admit those of one's own sex is significant at the 1% level for Out-patients but not at all for In-patients (chi-square test).

From among the admitting Subscribers some made more use of the Infirmary services than others. For instance, three Subscribers recommended 9 In-patients each, the highest In-patient number nominated in the twelve months. These three prolific Subscribers were George Tully[16] the Quaker preacher and architect, Mr. John Durbin[17] a future Govenor of the Bristol Corporation of the

Poor, and Richard Champion II[18] the Infirmary treasurer. The greatest numbers of Out-patient recommendations, 94 and 71 were made by Francis Bull[19] and John Bull[20] respectively. These two men both have addresses in the parish of Sts. Philip and Jacob, are both described as clothiers and both supported the Whig faction. Three other Subscribers, one a female, nominated over 50 Out-patients.

Was there a religious bias among the Subscribers? In the 18th century Bristol had large Nonconformist communities, Quakers and Unitarians being particularly prominent. The Quaker dynasties of Fry, Goldney, Harford, Lloyd and Rogers all had a number of members subscribing over the years and the participation of many within a single family line seems to be a Quaker characterisitc. This sect had a history of being generous donors to Infirmary funds. In 1751, in response to a specific call, a collection was made at all local places of worship. Nineteen churches and seven Nonconformist chapels contributed, a total of £344 18s 10 1/2d being raised. The `Fryers and Temple Street Meeting House' (Quakers) headed the list with £43 17s 6d, followed by Lewins Mead Chapel (Unitarian) with £35 16s 7d. However, it must be recognized that Quakers had only two meeting houses in Bristol and the Unitarians but one. The donations attributed to these congregations would therefore have arisen from a small number of worshipping communities but each having a large number of congregants, whereas the contribution from the Church of England was spread over nineteen congregations. Highest amongst the Anglican churches were St Nicholas's with a collection of £23, and All Saints with £17 6s 6d followed by St Augustine's at £17 5s 8d.[21] (It is of interest to note that All Saints was one of the smallest inner city parishes, having only 42 rated houses in 1751.[22] The sum contributed suggests a high level of involvement. Only two Subscribers have been positively identified with this parish but one of the two, William Barnes,[23] was a 3-guinea Subscriber whose father[24] was a 5-guinea Subscriber)

While denominations cannot be meaningfully compared with each other without more information than we have available here, it is of interest to note that betwen them the Quakers and Unitarians raised over 23% of the entire collection. Whether this reflects the amount of disposable income they had available, the influence they may have wished to wield, their humanitarian concern, or even the sheer weight of their numbers, is not known.

Being unable, within the limits of this project, to ascertain the religious affiliation of any patient, this question has not been posed. However, one of the strengths of the Quaker movement of this period was its provision for its own poor and when, in 1696, St Peter's Hospital was founded to serve the Bristol paupers, the Quakers responded by commissioning and staffing a Workhouse of their own and activly discouraged their members from making use of the public utility.[25] However, as so many Quakers were Infirmary Subscribers it is unlikely that the sick among their labouring poor co-religionists were ever dissuaded from using this facility, thus again distinguishing the constituency of the Infirmary from that of the Corporation of the Poor. The Infirmary was probably medically superior to either the Quakers' or the civic workhouse.

As we have seen, Unitarians also gave valuable support to the Infirmary and a number of their leading families, among them the Brices, Eltons, Garlicks and Deanes made generous contributions in both time and money. Edward Garlick I left £100 in his will executed in 1740 and his widow Hannah similarly gave £60 two years later.[26] Their son, Edward Garlick II, was also a Subscriber but his regular attendance at boards and committee meetings, where he bitterly criticised the running of the Infirmary, earned him an unenviable reputation, as may be inferred from his publications[27] and the answering *Animadversions* which will be referred to later in this chapter.

It is not doubted that valuable support came from members of other Nonconformist groups, among them Baptists and Congregationalists but it is unlikely that the membership of such groups would include many of the very prosperous as was the case among the Quakers and Unitarians. Since, however, it has not been possible to reconstruct the membership lists of these smaller groups no comparisons with the Infirmary's subscription lists has been made. We are therefore left to demonstrate a definite relationship between the Infirmary and these groups only by being alert to the fact that the names of five Nonconformist ministers of affiliations other than Quaker or Unitarian appear as Subscribers in the 1761 and 1762 subscription lists. This must suffice for evidence of their support.

The 17 parish churches and the Cathedral of Bristol were the focal point of the faith and strength of the established church. To judge by the number of Anglican clergy who were also hospital Subscribers (at least 30 holders of ecclesiatical office within Bristol have been identified as current Subscribers) it appears that a great deal of support came from this section of the community. In addition to the Head of the Grammar School and the Infirmary chaplain, the 1761 and 1762 subscription lists include 8 local vicars, 3 rectors and a curate, 7 other `reverends', 1 minor canon and 7 prebendaries of Bristol cathedral, the Chancellor of the diocese, the Bishop of Bristol and the Deans of Clogher, Gloucester, and Wells. None of these clergy, however, achieved such high ecclesiastical office as did Lord Seker, Bishop of Bristol in 1737, and an original Subscriber to the Infirmary, who was later translated to Canterbury to become Archbishop. It was in the exercise of this office that he crowned George III in 1760.

An attempt was made to trace the political views of the Subscribers through the 1754 Poll Book (the last before 1761). All Subscribers' names were checked and out of the total of 571 names, 140 were identified as having Whig sympathy while a further 81 favoured the Tories. Alignment

with the Whig party appears to be larger among Infirmary Subscribers than in the enfranchised population of Bristol as a whole if the behaviour in the 1754 poll still held good in 1761-2. This suggests to us that the trading interest in Bristol subscribed while property-based landed interests did not and this is corroborated by the names appearing in the Infirmary subscription lists of the period. Alternatively it could be argued that the Tories recruited poorer citizens as supporters. Both sitting Bristol Members of Parliament, Sir Jarrit Smith[28] (Tory) and Robert Nugent[29] (Whig), were Subscribers as were the two Tory Gloucester Members, Thomas Chester and Norbourne Berkeley.

Many civic leaders were Subscribers. Isaac Elton, Mayor in 1761, and John Noble who filled the office the following year; Stephen Nash, Governor of the Bristol Corporation of the Poor in 1762; Joseph Shapland, Master of St Stephen's Ringers 1761-2; Joseph Percival, President of the Colston Society 1761, and his immediate successor John Perks; and Henry Cotton, President of the Gloucester Society in 1761, all subscribed. A further 57 held either political or civic office in the 4 years before 1761 or the 4 years after 1762, 8 of them at the Corporation of the Poor, while many others held office at some time during their lifetimes.[30]

The titled were represented by 3 baronets; Sir Onesiphorus Paul,[31] Sir Abraham Isaac Elton[32] and Sir Charles Kemys Tynt.[33] Further baronetcies were later confirmed amongst the Subscribers; Sir Jarritt Smith[34] in 1763 and Norbourne Berkeley,[35] Member of Parliament for Gloucester from 1741 to 1763, in 1764. It is likely that the higher ranks were more usually associated by residence, interests and taste with the shire counties than with the commercial city.

Subscribers came from all of the parishes of Bristol, by residence, by trade or by freedom, but association with St James, the parish in which the Infirmary

stood, was the most frequent. However, the outer parishes were well represented, as were those in the nearer parts of Somerset and Gloucestershire. Nevertheless, support came from as far afield as Wells, Wales and London. The Reverend Dr. Creswicke, holder of the deanery of Wells Cathedral, had long been involved with Bristol Infirmary. His interest went as far back as the Infirmary's inauguration when he was `desired to take the Chair' at the first general meeting of the Subscribers held on 23rd December, 1736.[36] From Wales and through a life subscription came a Mrs. Bevan[37] and from Swansea an annual payment from a Mr. Bevan.[38] Three Subscribers, Capel Hanbury,[39] John Sage[40] and John Sargent[41] have been identified with places in London, possibly paying their dues through the good offices of Alderman Arnold whose appointment to receive such subscriptions had been recorded in the Minutes of 5th March, 1744.[42]

There is no evidence whatsoever that Overseers of the Poor were the Subscribers responsible for sending in patients from rural parishes. No corporate Subscribers in 1761-2 are parishes, neither is there any provision for parishes, either inside the city of Bristol or outside of it, either within the only Rule which deals with corporate subscriptions,[43] or elsewhere. It has not been possible to ascertain all the addresses of Subscribers recommending patients who came from outside Bristol but of those which have been ascertained a large proportion are Bristolians. In any case, only a few Subscribers referring patients from outside Bristol do so exclusively from one parish which may, or may not, be their own. James Johnson, writing as late as 1826, makes the observation that up to 1752 no parish subscription had been received but that `of late years, there were many who should not be permitted to subscribe'[44] and the wording he then proceeds to use indicates that parish subscription had recently been introduced. On this matter, see further the remark on Mrs. Fortune Little, below.

However, in the matter of vestry subscriptions Fissell differs. She states that `most Bristol Infirmary patients arrived in hospital because their parish vestry or poor-law overseer subscribed to the hospital'.[45] (Fissell is not referring to Bristol city parishes, the Poor Law services of which were united in a Corporation.) While a Subscriber recommending a country patient may or may not have been an overseer, there is evidence neither in Fissell's paper (apart from her unsupported assertion) nor in this study that this was a necessary or common pathway of admission. At some time later, probably fairly early in the 19th century, corporate subscriptions by vestries came into use[46] but Fissell indicates no date, cites no source for her evidence, and locates most of her work in a period earlier than that. Such is the effect of not distinguishing periods.

Due to the variety of addresses that might be given for a single individual, it has not been possible to plot accurately the geographical dispersement of Subscribers. For the same reason neither can their occupations be geographically plotted. However, there is sufficient internal and anecdotal evidence to support the picture of a bustling, thriving, multi-occupational city in the heyday of its prosperity, with many of its citizens willing to support their own city Infirmary and truly, support came from every quarter, men and women, old and young, Anglicans, Quakers, Unitarians and Presbyterians, Whigs and Tories, baronets and plain Mr.'s and Mrs.'s, tradesmen and professionals, public officers and holders of no office, Bristolians and non-Bristolians. If its influence was as far reaching as its supporters were varied, then the Bristol Infirmary was indeed becoming a force to be reckoned with, even though the whole world did not think kindly of every one of those supporters. Munro Smith quotes an unattributed source as describing one Subscriber, William Williams who kept a local Seminary, as `a pompous, ignorant old Pedagogue'![47]

It has not been possible to obtain information about every Subscriber, other than that she or he subscribed. However, Appendix 5 summarises the prosopographical material thus far gathered, concerning those subscribing to Bristol Infirmary in 1761 and 1762.

It is of interest to note that during the period under study, while there were on average 1.5 In-patient admissions and marginally over 4 Out-patient referrals per Subscriber, 4 of the clergy of St Mary Redcliffe, Redland, Temple and St Michael's churches between them recommended 16 In-patients and referred 39 others to the Out-patients. In contrast, the 10 officers of the Cathedral were responsible for the admission of only 3 In-patients and the referral to the Out-patients of 1 other. The only Dean to have exercised his nomination right was the Dean of Clogher with 2 admissions to his credit. This disparity within the ranks of the clergy may well reflect different degrees of contact with parishioners.

In the context of local religious leaders, George Tully the Quaker preacher and architect (referred to earlier in this chapter), was the most prolific recommender, with 9 patients admitted to the wards on his nomination and 26 others receiving Out-patient advice and treatment. Between them the 6 Nonconformist leaders admitted 16 patients and referred to the Out-patients 36 others.

Nominating patients from their own parish is a particular attribute of the clergy. Of the 16 patients of the Reverend John Price, Vicar of Temple parish, 15 gave Temple as their parish, and 5 of the 8 nominated by Reverend Thomas Broughton, Vicar of St Mary Redcliffe, similarly named that location as their domicile. From such nominating behaviour it may be inferred that, at a time when ministers of religion were medical advisers to the sick of the flock, (a point often missed by those writing upon the forerunners of the healing increasingly dominated by physicians, surgeons and apothecaries), the Infirmary could be a useful

adjunct to pastoral medicine. At the same time it is noticable that, although the Christian purpose of the Infirmary was explicit from the outset, no ecclesiastical organisation of any sort or of any denomination had constitutional power or privilege within it. As Jonathan Barry writes,[48]

> The Infirmary was a consciously ecumenical effort, attracting many Quakers, Anglicans and Presbyterians as supporters, and its management was held up as an example of what Christian ecumenism could achieve.

There are other examples of Subscribers nominating patients from a parish with which they had connections, either by residence, trade or religious worship. Mr. George Stoker,[49] with a confirmed address in Whitchurch, recommended 11 patients, 10 of whom came from his own parish. All 26 of Mrs. Fortune Little's[50] nominees came from Bedminster, the parish in which she herself lived. (On remarks already made about parish overseers, it is noteworthy that women were not overseers.) Of the 78 patients recommended by Mrs. Ann Baker,[51] whose own address has not been established, 73 came from Temple parish. On the other hand, Mr. Joseph Lewis[52] who had an address in Clifton, recommended 9 patients hailing from 8 different parishes, none of them Clifton. It could be that parsons and ladies know neighbours whereas men know those they meet during their work. It could also be that ladies and parsons know the homes of the poor.

Another group of Subscribers, the Huguenots, are characterised by their names. Peloquin, Piguenett, Casamajor and Laroche appear frequently. Mary Ann Peloquin's[53] charity in particular was renowned.[54] Apart from her 3-guinea annual subscription and bequest to the Infirmary of £5,000 she gave the enormous sum of £19,000 to Bristol corporation for the servicing of charitable activities. The building at 18, St. Augustine's Parade, Bristol, known as Peloquin Chambers, marks the spot where the Huguenots first landed. (Appendix 6 shows Mary Ann

Peloquin's family connections. It shows closeness to French roots and also may help to characterise, by example, the background of prosperity of the more lavish benefactors although, of course, Huguenots may not be typical among Bristolians.)

At this point it is appropriate to reiterate that the charity on which the Infirmary was founded was not simply a reflection of the needs of the `sick poor'; it was a merchant- and manufacturer-based economical measure energised by a Christian ideology that was in turn underpinned by the dual national need to increase the size of the population and to provide a workforce large enough to supply adequate skilled labour. Such was the `mortar' of the charity; the `building blocks' may well have been personal concern for the poor. It is in the `building blocks' that the intention of the charitable act can be seen to be realized in its consequences.[55]

Six representative Subscribers, jointly with the patients each admitted, will now be considered as 6 distinct groups. Using this method the fine grain of some of Bristol Infirmary's personal relationships can be better brought into focus. The selection of the 6 Subscribers for this investigation has been governed by the availability of information but it has frequently been difficult to discriminate fully between contemporaries of the same name. Nevertheless accuracy has been aimed for and those selected are a good representation of the whole body of Subscribers.

The first Subscriber to be considered is John Hooper.[56] John Hooper was a 2-guinea Subscriber and admitted a total of 4 patients to the Infirmary, 1 In-patient and 3 Out-patients. No discrimination concerning either sex or age is evident and the medical conditions of his nominees reflect the usual problems of the time and area, a condition of a malarial kind, ophthalmia, pain of the limbs, and sciatica, and all the patients originated from a cluster of parishes around the city centre. The 1754

Poll Book lists a John Hooper as a feltmaker, with an address in St. Mary Redcliffe and notes that he cast his vote in favour of the Whig party. John Hooper's patients found relief for their conditions at the Infirmary; three were discharged `Cured' and the fourth `Relieved'. The 1 In-patient was warded for three weeks and none had a second admission to the Infirmary during the year.

More information is known to us about the second Subscriber selected - Mr. Jno. Clark.[57] Like John Hooper, Jno. Clark was a 2-guinea Subscriber but, unlike John Hooper, he made much use of his patronage, being responsible for 8 In-patient and 18 Out-patient admissions, a total of 24 people. He too admitted across a wide age range, from 3 toddlers as Out-patients to a 70-year-old male to the ward, but no sex bias is apparent and, again, the medical conditions are those generally to be found at the time.

The 1754 Poll Book records a blacksmith, John Clark by name, from St. James, casting a Tory vote while the Society of Friends lists the name among its members. It is of interest to note both that 20 out of 26 of Jno. Clark's patients came from St. James and that 2 of these patients suffered scalds either to their feet or legs. It cannot be said with any degree of certainty that these scalds were employment-related; one case concerned the ten-year- old El. Woodward,[58] and the other patient, Xn. Blower,[59] had a period as an Out-patient during which time his malady was described as `cancer on the foot'. Both El. Woodward and Xn. Blower were admitted during the period when Jno. Clark had another patient warded. Normally John Clark was scrupulous about observing the `only one at a time' rule. The only other occasion when he did disregard it (or, perhaps, the only time he was allowed to disregard it?) was when he admitted a 35-year-old man with peripneumonia notha (a `spurious' form of pneumonia) whose illness was to prove fatal within a short time. It is tempting to toy with the idea of a 2 guinea annual subscription being a form of

employer's insurance contribution but it cannot be substantiated on the evidence we have here.

Two of Jno. Clark's patients illustrate possible record-keeping problems at the Infirmary. Henry Dawkins[60] was admitted to Out-patients on 16th August, 1762 and not discharged until 22nd November of that year. However he is also recorded as being an In-patient from 23rd August, 1762 to 27th September, 1762,[61] thus his In-patient time is completely embedded in his Out-patient period. With the substitition of different dates the same situation applied to the patient, Xn. Blower. This tactic could be a neat dodge to inflate the activity of the Infirmary by implying a longer period of care as an Out-patient than was actually the case, but there is no overwhelming reason to favour this explanation. However, overall Jno. Clark's 2 guinea subscription netted him nine patient-months of In-patient care alone.

As will be shown later in this chapter, a year's In-patient care for provisions alone costs in the order of £6 10s 0d. Jno. Clark himself may have had value for money, but he could obtain services only as far as others were denied. However, though costly, most of his patients found their stay at the Infirmary beneficial. Of his 8 In-patients 6 were discharged `Cured', 1 died and another was discharged to the Out-patients (although there is no evidence that she arrived there).

To represent the ecclesiastical element among the Subscribers the activity of Reverend Mr. Charles Goddard[62] may be reviewed. Medical attendance by parsons on parishioners was a normal occurrence at this period. Indeed, not long after, in 1801 Thomas Beddoes, founder of the Pneumatic Institute in Dowry Square, Bristol, included an essay entitled, `To Ministers of the Gospel of Every Denomination', in his work *Hygeia*, requesting parsons (with special reference to John Wesley!) not to presume overmuch

about their knowledge of medicine, but to recognize the need for a physician.[63]

> The active mind of JOHN WESLEY would not suffer him to leave his congregation without the best counsel he could provide against the season of sickness - But the primitive physic of this modern apostle is, I fear, fit only for a primitive age - that is, an age which wants none. In general, to caution the unwary against self-neglect, is the point at which you should make a conscience of stopping.

This reference to John Wesley was no doubt in response to the publication by Wesley of a medical manual he had prepared for his followers' own use and as an aid in their caring for each other.[64]

The Reverend Charles Goddard was a 2-guinea Subscriber and is recorded in the 1754 Poll Book as voting Tory and as holding the office of Clerk in Temple, one of the riverside city parishes. An address in Barrow, Somerset is also given for him. Rev. Goddard admitted 3 In-patients during the year but no Out-patients. Of his patients 2 were from Portbury and 1 a stranger with no named parish. (Portbury was a dock area about eight miles from Barrow Gurney which is possibly the Barrow referred to in the given address).

The stranger, a male, was known to be suffering from syphilis when admitted yet this was a condition expressly forbidden by the Rules[65] but of which there were a fair sprinkling of In-patient cases throughout the year. (It is of interest to note that of the 21 `strangers' admitted during the year 7 were suffering from venereal disease.) Whether this particular patient sought the intervention of a clergyman because he knew no-one else suitable in the neighbourhood, or whether he trusted that admission by the good offices of a man of the cloth would absolve him of the association of sin, can only be conjectured. Of the 2 patients from Portbury 1 was found to be pregnant, again one of the forbidden categories of

conditions, though to be fair, this patient was, on admission, presumed to be suffering from dropsy. Perhaps it was the nature of the problem that caused this female patient to seek the intervention of a minister of the church, as in the case of the stranger suffering from syphilis? However, once the correct diagnosis had been ascertained she was discharged as admitted `Against Rules'. The other patient had an abscess of the cheek for which he was warded just one week. With only 3 patients to his credit Rev. Goddard did, nevertheless, manage some overlapping, but in total took up only 75 days of patient care.

Dr. John Page,[66] who will be considered next, began his medical career as a surgical apprentice to his father, Dr. Thomas Page, a surgeon at the Bristol Infirmary. It is said of John Page that he used to boast that he was the first person ever to have surgically dressed a patient at the Infirmary.[67] Upon the death in 1741 of Dr. Page, Senior, John Page succeeded to his father's position and remained on the staff of the Bristol Infirmary until 1777. An interesting description is given of the younger Dr. Page by Munro Smith and is quoted here in full.[68]

> He was twenty-eight years of age when he came on the Infirmary Staff, and he soon became well known as a man of sound judgment and knowledge. He is described as a "good, steady operator," and became famous for his operations on stone in the bladder, an operation which in those days was considered the greatest test of a man's skill as a surgeon, requiring a steady hand, a keen eye, anatomical knowledge, coolness and judgment. His results were very good. It was he who used to remove fingers and toes with a chisel, and students were in the habit of saying that "Johnny was going to play at hammer, chisel and block!" He was fond of long prescriptions containing a farrago of drugs now considered almost useless, and was a great advocate of balsams and ointments.

Though honorary, medical staff who wished to admit patients still had to pay a subscription and Dr. John Page, like his father before him, was a 2-guinea Subscriber. Dr.

Page admitted 6 In-patients and 1 Out-patient during the year and both the conditions referred to by Munro Smith above are in evidence; a 57-year-old man from Wotton-under-Edge suffering from a bladder stone, a 30-year-old male with a carious finger and a 21-year-old stranger with a carious tibia. It is a reflection of the severe pain caused by urinary calculi that affected patients were prepared to travel long distances for relief, the motion of travel itself exacerbating the pain, and occasionally to subject themselves to the horrors and dangers of operation. Dr. Page's patient appears to have escaped without surgical intervention though even after 21 weeks of care he was discharged merely as `Relieved'. The discharge states of the 2 patients with bone caries tell their own story. The 1 with the tibial infection took his own discharge the day after admission and the other was sent away on account of bad behaviour and, presumably, before the surgeon could get the hammer and chisel to him!

Relationships between this Subscriber and his patients appear to be confined to the medical condition suffered by the patient on the one hand and the medical expertness available from the doctor on the other. No sex or age bias and no correlation of addresses can be found in the parishes of origin of the patients, with only 1 of the 7 coming from St. James, the only address found to be associated with Dr. Page himself. There appears at times to be some discretion in enforcing the `only one at a time' rule and to this supposition Dr. Page's patients lend weight, for both of the patients suffering from caries had their entire hospital stay during the time when another patient of Dr. Page was already in the wards. Perhaps, because of Dr. Page's known skill in surgery he may have been allowed this extra leeway. Again, Dr. Page was one of those Subscribers who used his nomination power to the utmmost, and he secured 356 days of In-patient care for his 2 guineas.

Mrs. Fortune Little[69] is the Subscriber *par excellence* to demonstrate parish correlations, for all of the 8 In-patients and 18 Out-patients she nominated were from her own parish of Bedminster. However, there is no direct evidence that any of the patients were from her own household at 164 Bedminster, but that she was well known locally for her piety and virtue is attested to by the wall plaque that is consecrated to her memory in the parish church of St. Mary Redcliffe (a parish coterminous with Bedminster). The inscribed verse on it, composed by her friend Hannah More, the educationist, is given below.

> Oh! could this verse her bright example spread,
> And teach the living while it prais'd the dead:
> Then, reader, should it speak her hope divine,
> Not to record her faith, but to strengthen thine;
> Then should her evr'y virtue stand confess'd,
> `Till every virtue kindled in thy breast:
> But if thou slight the monitory strain
> And she has liv'd to thee at least in vain,
> Yet let her death an awful lesson give,
> The dying Christian speaks to all that live;
> Enough for her, that here her ashes rest
> `Till God's own plaudit shall her worth attest.

Hannah More herself was a great friend to Bristol Infirmary and left £1,000 to the institution upon her death in 1833[70]. She was also romantically involved with William Turner, a member of the Building committee in the 1780's, who was to make a £1,000 donation towards the cost of a new building for the Infirmary later in the decade. Mr. Turner could never quite get himself to the altar and insisted upon making a financial settlement on Hannah More to ease his conscience. Rev. Sir James Stonehouse who was acting for Mr. Turner thought that `part of the sum proposed might be accepted without the sacrifice of delicacy' whereupon the protesting Hannah More received an annuity of £200.[71] In his turn, there is a story associated with the Bristol Infirmary about this same Rev. Sir John Stonehouse.[72]

Apart from the originating parish no bias can be detected in Mrs. Little's nominations. Certainly she did not admit more of her own sex than of the opposite. Mrs.

Little admitted across the age range, with a wide variety of distempers which included a 40-year-old male with syphilis. Generally her patients had only short Infirmary stays and therefore very little overlapping of nominations is found. However there was one patient who remained in hospital for 18 weeks. Mrs. Little was a 2-guinea Subscriber and obtained 265 days of In-patient care for her fellow-parishioners.

George Tully[73] is the last Subscriber to be considered here. Like the other 3 Subscribers mentioned he made an annual subscription of 2 guineas and was responsible for admitting 9 In-patients and 26 Out-patients. We know of George Tully that he was the architect and builder of the Friends Meeting House in Quakers Friars, Bristol[74] and that he probably served in the same capacity for John Wesley's New Room in Broadmead, Bristol.[75] In 1749 Tully lodged plans with the building sub-committee of the Infirmary for the erection of their new West Wing.[76] We also know from the 1754 Poll Book that George Tully's own house was in the prosperous, and, still now, handsome, King's Square, St. James, that he was a Quaker preacher and that he cast his vote for the Whigs. From an entry in the Minute Book dated 4th December, 1750 we learn that he was a member of the Infirmary Brewing committee.

Although so much is known to us about George Tully little is known about his patients. They form a homogeneous group within the framework of their benefactor's high profile. The sexes were catered for equally, medical conditions were of the run of the mill variety and all patients apparently benefitted from their stay.

Little attention seems to have been given to the `only one at a time' rule for, on more than one occasion George Tully had 3 of his nominees in the wards together. With 612 days to his credit he was the second biggest user of the In-patient facilities if they are judged by days of patient care acquired over the twelve months.

Much of the activity in which George Tully's employees engaged must have been hazardous in the extreme. At this period scaffolding was of simple, wooden construction, the constituent parts being lashed together with rope, with the resultant structure providing insecure footholds. Ladders were of the same type of construction and provided the same type of hazard. It is possible that greater risks than now were taken by employees either on their own initiative or encouraged by their employer, for there were no Health and Safety regulations in force at the time to maximise safety.

It is known that 8 other Infirmary Subscribers were connected with the building industry either as joiners, tilers, carpenters, housebuilders or shipbuilders, and yet very few accident cases were admitted by any of them. Apart from the 15-year-old male admitted by George Tully with a fracture of the arm only 4 other sufferers from injuries, all minor and all male, were seen as Out-patients and none as In-patients on the nomination of these 8 Subscribers. This seems to confirm that any notion of an Infirmary subscription being used as a workplace insurance premium is unlikely.

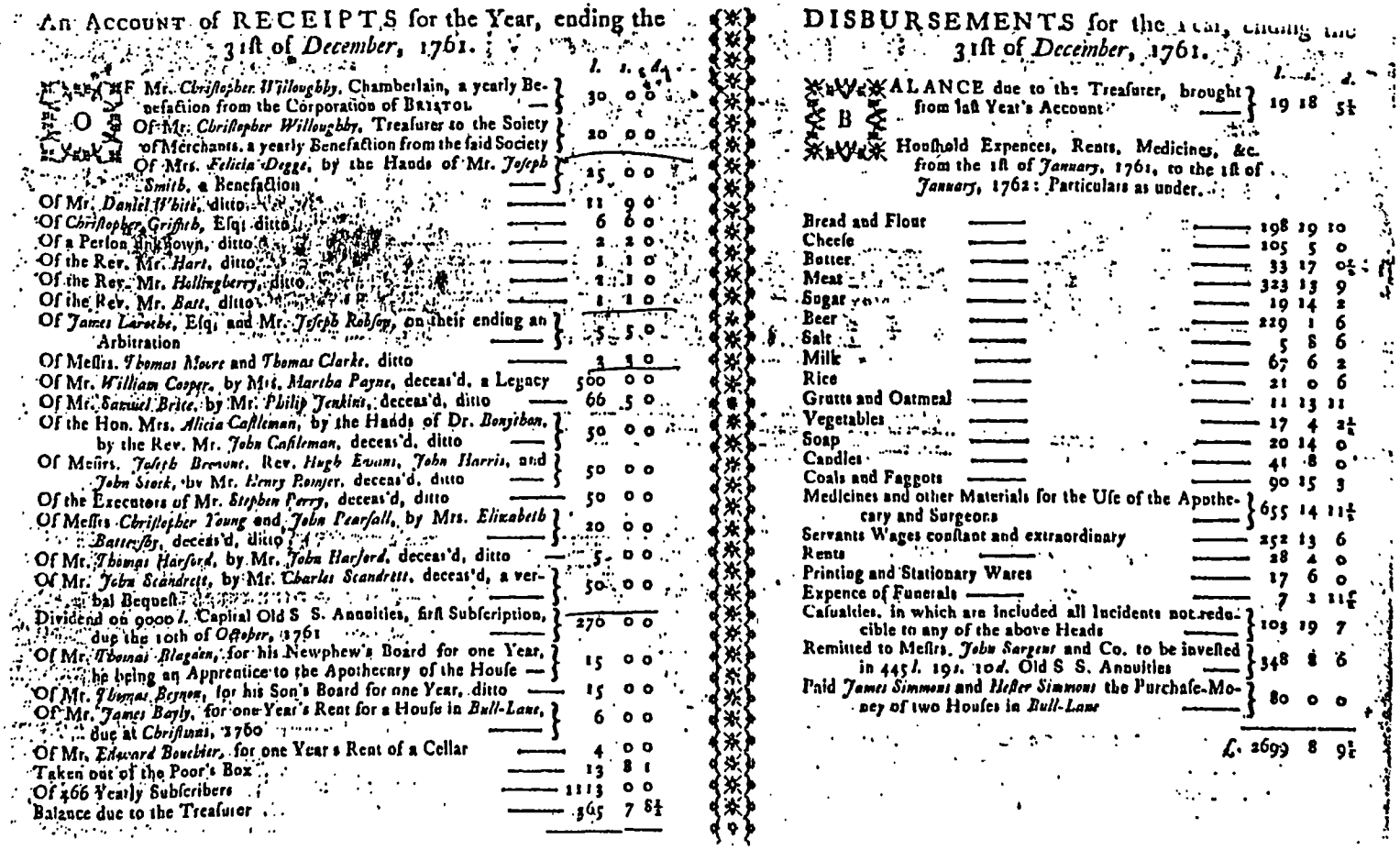
Yet Bristol was expanding, has left us many buildings of the mid-18th century, and must have been alive with building projects. What happened to the workers unfortunate enough to sustain an injury on the job? We can now stand aside and look. There were 10 patients with fractures admitted by Subscribers, 3 male In-patients and 2 male Out-patients, 2 female In-patients and 3 female Out-patients. If we turn now to patients admitted as Casualties (all In-patients therefore) the figures are in stark contrast. Here, of the 48 patients with fractures, 39 were male and only 9 female. Building being exclusivly a male occupation at the time, one is nudged to the conclusion that employers in the construction industry were able to get their injured employees to hospital as Casualties. It is possible that an employer would not feel at liberty to take

advantage of free treatment for his injured employees as Casualties unless he, the employer, was making some contribution to Infirmary funds. His fellow employers doubtless would have ways of ensuring this. Of course, seeking treatment might have been due wholly to the injured one.

This selection of Subscribers' prosopographies and notes on their relation to patients reflects the public standing of many of the Subscribers. Reference to them can be found in the Poll books, street directories, church membership lists, contemporary literature and, for a few at least, there is posthumous fame in the form of public memorials.[77] In their activities as Subscribers they largely followed the Rules, sending for admission only those patients whose category of illness was acceptable to the Infirmary (with the notable exception of venereal disease), and usually spacing their nominations to avoid overlapping one patient with another. A tendency to admit patients from parishes with which they themselves are associated is evident but no case can be made out that the subscription was being used as a form of employer's insurance.

2.3 INCOME AND EXPENDITURE AT THE BRISTOL INFIRMARY, 1761 AND 1762

Constrained by the availability of the Registers, the data for this work is based on the last quarter of 1761 and the first three quarters of 1762. The Infirmary published abstracts of their accounts in the annual Infirmary States and also annually in the Bristol weekly newspapers, and followed the calendar year of 1st January to 31st December. (See Figs. 2.2 and 2.3 below for copies of the abstracted accounts for the years of 1761 and 1762 as they appear in the States.) It has not been possible to reconcile the published abstracts of accounts with the precise period of the data under review. Therefore the accounts for the two full calendar years will now be considered and applied to the data of September 1761 to September 1762 as appropriate.



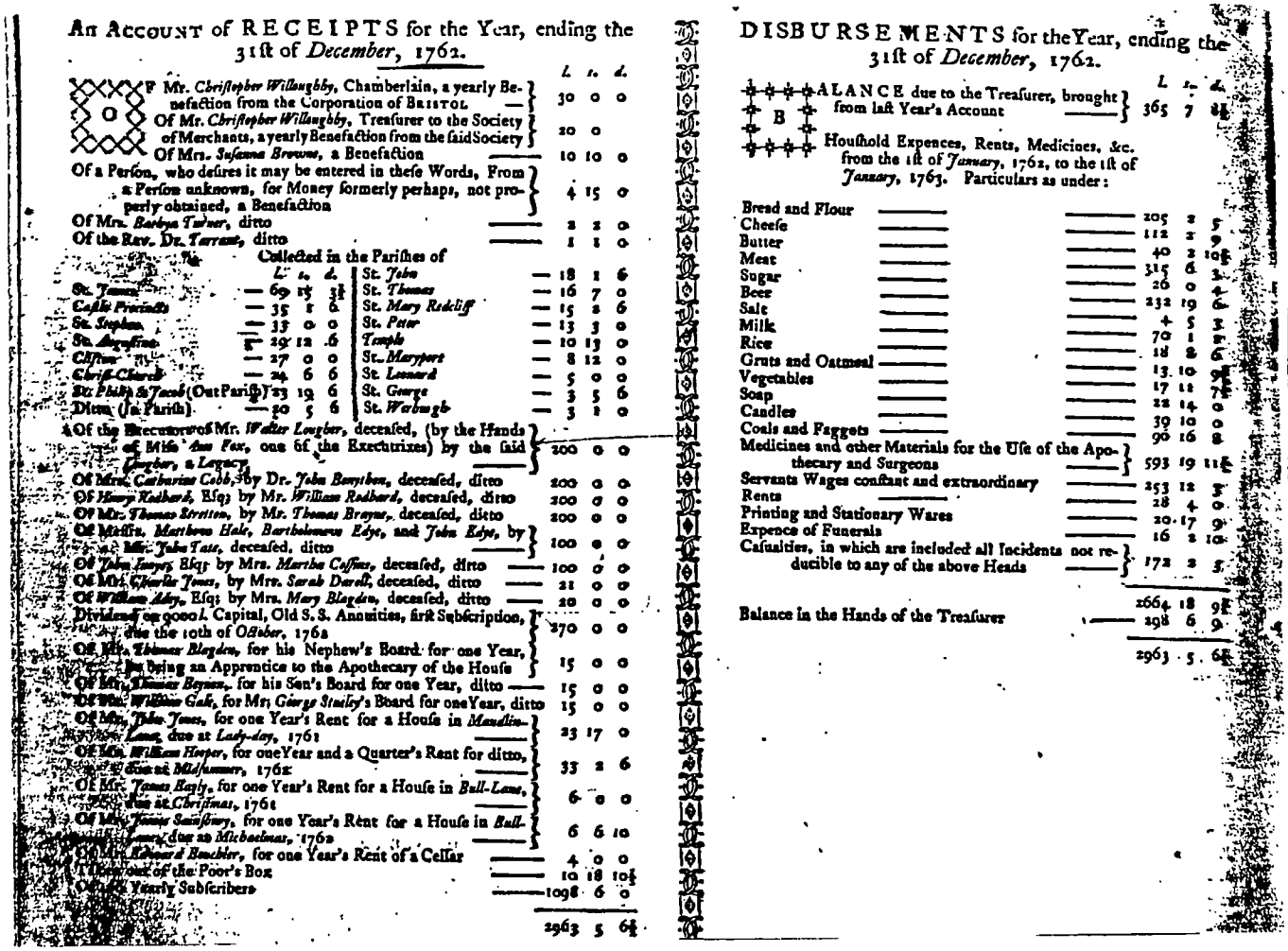
An ACCOUNT of RECEIPTS for the Year, ending the 31ſt of *December*, 1761.

		l.	s.	d.
OF	Mr. *Chriſtopher Willoughby*, Chamberlain, a yearly Beneſaction from the Corporation of BRISTOL	30	0	0
	Of Mr. *Chriſtopher Willoughby*, Treaſurer to the Society of Merchants, a yearly Beneſaction from the ſaid Society	20	0	0
	Of Mrs. *Felicia Degge*, by the Hands of Mr. *Joſeph Smith*, a Beneſaction	25	0	0
	Of Mr. *Daniel White*, ditto	11	9	0
	Of *Chriſtopher Griffith*, Eſq; ditto	6	6	0
	Of a Perſon unknown, ditto	2	2	0
	Of the Rev. Mr. *Hart*, ditto	1	1	0
	Of the Rev. Mr. *Hellingberry*, ditto	1	1	0
	Of the Rev. Mr. *Batt*, ditto	1	1	0
	Of *James Larothe*, Eſq; and Mr. *Joſeph Robſon*, on their ending an Arbitration	5	5	0
	Of Meſſrs. *Thomas Moore* and *Thomas Clarke*, ditto	3	3	0
	Of Mr. *William Cooper*, by Mrs. *Martha Payne*, deceas'd, a Legacy	500	0	0
	Of Mr. *Samuel Brice*, by Mr. *Philip Jenkins*, deceas'd, ditto	66	5	0
	Of the Hon. Mrs. *Alicia Caſtleman*, by the Hands of Dr. *Benjiban*, by the Rev. Mr. *John Caſtleman*, deceas'd, ditto	50	0	0
	Of Meſſrs. *Joſeph Bremont*, Rev. *Hugh Evans*, *John Harris*, and *John Stock*, by Mr. *Henry Bonjer*, deceas'd, ditto	50	0	0
	Of the Executors of Mr. *Stephen Perry*, deceas'd, ditto	50	0	0
	Of Meſſrs *Chriſtopher Young* and *John Pearſall*, by Mrs. *Elizabeth Batterſby*, deceas'd, ditto	20	0	0
	Of Mr. *Thomas Harford*, by Mr. *John Harford*, deceas'd, ditto	5	0	0
	Of Mr. *John Scandrett*, by Mr. *Charles Scandrett*, deceas'd, a verbal Bequeſt	50	0	0
	Dividend on 9000 *l.* Capital Old S S. Annuities, firſt Subſcription, due the 10th of *October*, 1761	270	0	0
	Of Mr. *Thomas Blagden*, for his Newphew's Board for one Year, he being an Apprentice to the Apothecary of the Houſe	15	0	0
	Of Mr. *Thomas Beynon*, for his Son's Board for one Year, ditto	15	0	0
	Of Mr. *James Bayly*, for one Year's Rent for a Houſe in *Bull-Lane*, due at *Chriſtmas*, 1760	6	0	0
	Of Mr. *Edward Bouchier*, for one Year's Rent of a Cellar	4	0	0
	Taken out of the Poor's Box	13	8	1
	Of 366 Yearly Subſcribers	1113	0	0
	Balance due to the Treaſurer	345	7	8½

DISBURSEMENTS for the Year, ending the 31ſt of *December*, 1761.

		l.	s.	d.
BALANCE	due to the Treaſurer, brought from laſt Year's Account	19	18	5½
	Houſhold Expences, Rents, Medicines, &c. from the 1ſt of *January*, 1761, to the 1ſt of *January*, 1762: Particulars as under.			
	Bread and Flour	198	19	10
	Cheeſe	105	5	0
	Butter	33	17	0½
	Meat	323	13	9
	Sugar	19	14	2
	Beer	229	1	6
	Salt	5	8	6
	Milk	67	6	2
	Rice	21	0	6
	Grutts and Oatmeal	11	13	11
	Vegetables	17	4	2½
	Soap	20	14	0
	Candles	41	8	0
	Coals and Faggots	90	15	3
	Medicines and other Materials for the Uſe of the Apothecary and Surgeons	655	14	11½
	Servants Wages conſtant and extraordinary	252	13	6
	Rents	28	4	0
	Printing and Stationary Wares	17	6	0
	Expence of Funerals	7	2	11½
	Caſualties, in which are included all Incidents not reducible to any of the above Heads	103	19	7
	Remitted to Meſſrs. *John Sargent* and Co. to be inveſted in 445 *l.* 19*s.* 10*d.* Old S S. Annuities	348	8	6
	Paid *James Simmons* and *Heſter Simmons* the Purchaſe-Money of two Houſes in *Bull-Lane*	80	0	0
		£. 2693	8	9½

Fig. 2.2 ABSTRACT OF ACCOUNTS TAKEN FROM *BRISTOL INFIRMARY STATE* FOR THE YEAR 1761



An Account of RECEIPTS for the Year, ending the 31st of *December*, 1762.

	L.	s.	d.
Of Mr. *Christopher Willoughby*, Chamberlain, a yearly Benefaction from the Corporation of Bristol	30	0	0
Of Mr. *Christopher Willoughby*, Treasurer to the Society of Merchants, a yearly Benefaction from the said Society	20	0	
Of Mrs. *Susanna Browne*, a Benefaction	10	10	0
Of a Person, who desires it may be entered in these Words, From a Person unknown, for Money formerly perhaps, not properly obtained, a Benefaction	4	15	0
Of Mrs. *Barbra Turner*, ditto	2	2	0
Of the Rev. Dr. *Tarrant*, ditto	1	1	0

Collected in the Parishes of

	L.	s.	d.		L.	s.	d.
St. James	69	15	3½	St. John	18	1	6
Castle Precincts	35	1	0	St. Thomas	16	7	0
St. Stephen	33	0	0	St. Mary Redcliff	15	2	6
St. Augustine	29	12	6	St. Peter	13	3	0
Clifton	27	0	0	Temple	10	13	0
Christ Church	24	6	6	St. Maryport	8	12	0
St. Philip & Jacob (Out Parish)	23	19	6	St. Leonard	5	0	0
Ditto (In Parish)	20	5	6	St. George	3	5	6
				St. Werburgh	3	1	0

Of the Executors of Mr. *Walter Langher*, deceased, (by the Hands of Miss *Ann Fox*, one of the Executrixes) by the said *Langher*, a Legacy	200	0	0
Of Mrs. *Catharine Cobb*, by Dr. *John Bamyben*, deceased, ditto	200	0	0
Of *Henry Redbard*, Esq; by Mr. *William Redbard*, deceased, ditto	200	0	0
Of Mr. *Thomas Stretton*, by Mr. *Thomas Brayne*, deceased, ditto	200	0	0
Of Meſſrs. *Matthew Hale*, *Bartholomew Edye*, and *John Edye*, by Mr. *John Tate*, deceased, ditto	100	0	0
Of *John Jones*, Esq; by Mrs. *Martha Coſſins*, deceased, ditto	100	0	0
Of Mrs. *Charlotte Jones*, by Mrs. *Sarah Durell*, deceased, ditto	21	0	0
Of *William Addy*, Esq; by Mrs. *Mary Blagden*, deceased, ditto	20	0	0
Dividend on 9000*l.* Capital, Old S. S. Annuities, firſt Subſcription, due the 10th of *October*, 1762	270	0	0
Of Mr. *Thomas Blagden*, for his Nephew's Board for one Year, for being an Apprentice to the Apothecary of the Houſe	15	0	0
Of Mr. *Thomas Bayne*, for his Son's Board for one Year, ditto	15	0	0
Of Mr. *William Gale*, for Mr. *George Stanley*'s Board for one Year, ditto	15	0	0
Of Mrs. *John Jones*, for one Year's Rent for a Houſe in *Mandlin-Lane*, due at *Lady-day*, 1762	23	17	0
Of Mr. *William Hooper*, for one Year and a Quarter's Rent for ditto, due at *Midſummer*, 1762	33	2	6
Of Mr. *James Hayly*, for one Year's Rent for a Houſe in *Bull-Lane*, due at *Chriſtmas*, 1761	6	0	0
Of Mrs. *Jane Sainſbury*, for one Year's Rent for a Houſe in *Bull-Lane*, due at *Michaelmas*, 1762	6	6	10
Of Mr. *Edward Bouchier*, for one Year's Rent of a Cellar	4	0	0
Of Ditto out of the Poor's Box	10	18	10½
Of the Yearly Subſcribers	1098	6	0
	2963	5	6½

DISBURSEMENTS for the Year, ending the 31ſt of *December*, 1762.

	L.	s.	d.
BALANCE due to the Treaſurer, brought from laſt Year's Account	365	7	8½
Houſhold Expences, Rents, Medicines, &c. from the 1ſt of *January*, 1762, to the 1ſt of *January*, 1763. Particulars as under:			
Bread and Flour	205	2	5
Cheeſe	112	2	9
Butter	40	2	10½
Meat	315	6	3
Sugar	26	0	4
Beer	232	19	6
Salt	4	5	3
Milk	70	1	8
Rice	18	8	6
Grats and Oatmeal	13	10	9½
Vegetables	17	11	7½
Soap	22	14	0
Candles	39	10	0
Coals and Faggots	90	16	8
Medicines and other Materials for the Uſe of the Apothecary and Surgeons	593	19	11½
Servants Wages conſtant and extraordinary	253	12	5
Rents	28	4	0
Printing and Stationary Wares	20	17	9
Expence of Funerals	16	2	10
Caſualties, in which are included all Incidents not reducible to any of the above Heads	172	2	5
	2664	18	9½
Balance in the Hands of the Treaſurer	298	6	9
	2963	5	6½

Fig. 2.3 ABSTRACT OF ACCOUNTS TAKEN FROM *BRISTOL INFIRMARY STATE* FOR THE YEAR 1762

Courtesy of Bristol City Archives

The Infirmary committee, elected annually by Subscribers from among themselves, included among its numbers Richard Champion II, the Treasurer.[78] Richard Champion II inherited the position at the death of his brother Nehemiah. Nehemiah in his turn had received the office from their father, Richard Champion I. For a short period following the death of Richard Champion II the post was held by A.R. Hawkesworth before reverting to the Champion family in the person of Richard Champion III, grandson of Richard Champion I and nephew of Richard Champion II.[79] The Champion family were closely associated with the Quaker sect and had business interests as merchants and manufacturers.

The duties of the Treasurer were as exacting as his fortune needed to be large. Treasurers were required to deposit a penal bond of £5,000 as security for the safe-keeping of the Infirmary's monies immediately upon taking up their appointment[80]. In line with recognised procedure the post was honorary.[81]

Abstracts from the Treasurer's accounts were incorporated within the published annual States. For 1761 the accounts, agreed at the year's end at £2,699 8s 9 1/2d, could only be reconciled by a loan from the Treasurer, probably taken from the penal bond, of £365 7s 8 1/2d. This debit balance was brought about by a new investment of £348 8s 6d in Old South Sea Annuities. The loan from the Treasurer was repaid in 1762 and at the end of this financial year there was a credit balance of £298 6s 9d.

Over the two years there were 11 benefactions which brought in a total of £66 8s 0d. The benefaction of £4 15s 0d from `a Person, who desires it may be entered in these Words, From a Person unknown, for Money formerly perhaps, not properly obtained', sounds like conscience money! There was 1 other `Unknown' benefaction of £2.2s 0d. Between them, 3 women gave £37 12s 0d and 2 men a further £17 15s 0d. The 4 £1.1s 0d benefactions were attributed to

clerics. The clerics possibly were not the source of this money but, more probably, the channel. In 1741 it had been agreed that benefactions of £50 or more should be placed out at interest in a Standing Fund[82] though Munro Smith points out that this decision was not always adhered to. In neither of these two years was any benefaction large enough to qualify.

Further, over the two years 16 legacies increased the Infirmary's income by a total of £1,832 5s 0d. Only 7 were from former Subscribers. Money which had come to the Infirmary in this and similar ways in earlier years, and which had been invested in South Sea Annuities, showed a dividend of £270 in both years.

At this period in the history of Bristol personal disputes were often settled by an `arbitrator' or `referee' rather than by recourse to law. *Munro Smith explains the* custom and relates how the finances of the Bristol Infirmary came to benefit by it.[83]

> It became the custom about the year 1743 for the disputants to deposit each a guinea or so in the hands of these referees, who usually gave this money to the Infirmary.

In 1761 the Infirmary twice benefitted by this custom; the first time by a payment of £5 5s 0d and the second by £3 3s 0d, both noticably higher than Munro Smith's comment suggests. Both disputants concerned in the £5 5s 0d payment were Infirmary Subscribers. There is no evidence that either of the other two were.

Parish collections were resorted to from time to time when finances were particularly low. In 1751, the nearest occurrence preceeding 1761, £344 18s 10 1/2d was raised,[84] a figure very close to that of the £356 6s 3 1/2d raised in 1762. This latter figure is also very close to the amount lent by the Treasurer in the previous year and the amount which was invested in the Old South Sea

Annuities. It appears as if the Treasurer may have had an uncanny instinct when it came to assessing public giving!

Payment for board from apprentice apothecaries, 3 in the first year and 2 in the second, together with rents from sundry buildings, combined to add a further £158 6s 4d. The Infirmary's Poor Box yielded £24 6s 11 1/2d over the two years.

However, it was the annual subscriptions which provided the income for the day-to-day running of the Infirmary and were certainly the largest and most dependable source of income to come in regularly.

At its outset the Founders of the Infirmary had to determine the level of subscription that would be most likely to achieve financial stability and 2 guineas was decided upon, with any amount over 20 guineas qualifying for life membership.[85] Over 82% of the subscriptions were of 2 guineas. This 82% is to be seen in comparison to the early years of the enterprise when only 66% in 1737 and 74% in 1738 were 2-guinea Subscribers. The earlier Subscriber behaviour, giving larger subscriptions more often, may have been an initial surge, the result of a new challenge to well-wishers' generosity, calling for new support which then become unsustainable over a longer period. It could also be that more previuosly indigent Bristolians were now in a postion to afford an annual 2-guineas or that the increase in population provided the Infirmary with a larger pool from which 2-guinea contributors would come.

From the abstracts of accounts in Figs. 2.2 and 2.3 it will be seen that provisions were the largest single expense, £1,033 4s 7d in 1761 and £1,055 7s 8 1/2d in 1762. Expressed as a total of outgoings in each year these figures represent 38.3% and 35.6% respectively. The foodstuffs on which this money was laid out appear to be capable of ensuring a reasonable, if basic, diet. Bread, flour, cheese, butter, meat, sugar, beer, salt, milk, rice, groats,

oatmeal and vegetables are all listed in the accounts. It was Matron's responsibility to buy in all the food[86] the money being made available, generally on a weekly basis, by the Treasurer.[87] Usually there was a significantly higher payment in the final week of each quarter. Whether this reflects the presentation of bills by the supplier or an earlier desire not to overspend a limited budget is open to speculation but discretion and good housekeeping are the hallmark of both a good housekeeper and a good treasurer.

In addition to the 132 beds which were constantly in use, (and discounting any doubling-up or extra beds,) and with 132 patients therefore requiring food on a regular basis, 26 employees[88] had to be fed, and fed well.[89] Assuming that patients and employees were fed on equal terms, to provision one `bed' or one employee for the year 1761 cost £6 10s 6d and the following year £6 13s 6d. (There appears to be little relationship between these figures and those quoted by Porter for Northampton Infirmary[90]). As the average length of stay per patient was marginally less than seven weeks, the cost of provisioning a single In-patient would have been in the region of 17s. 6d..

Out-patients would have cost much less than In-patients but as we do not know how to distribute cash flow between In- and Out-patients no estimate of *per capita* costs can be made.

The medicine bill, itemised as `Medicine and other Materials for the Use of the Apothecary and Surgeons', was the second largest item to be budgeted for. In 1761 it accounted for 24.3% of the year's outlay and in the next year 25.9%. These figures are unsurprising given the extensive Pharmacopoeia which was in use at the time.[91] Drugs could only be purchased with permission from the Committee, except in cases of emergency. Even so, the purchase had to be authorised by a signed order from one of the medical staff.[92] Living zoological medicaments for the

use of the Apothecary and surgeons' would certainly have included leeches.[93] The medicine bill also included artificial legs. Indeed there were those in the city who complained that `Elbridge's Butchers...were filling the streets with wooden legs'.[94] An Inventory item for 1750 noted that in the Matron's apartment there were 44 pairs of sheets `fit only for the Surgeons'. It appears that sheets more than three fourths worn could be torn up and used as bandages, but Matron's Inventory shows that, in 1751, 36 new sheets were so used.[95]

There is no way of determining the proportion of medical supplies spent on In-patients as opposed to Out-patients but assuming that supplies were used in equal proportion to the numbers of patients treated, each patient, on average, would have incurred the Infirmary in a bill of around 3s. 6d.. The writer of the Animadvertory Letter put the cost at 3s.1 1/2d. per patient in 1762 at which level it made the Bristol Infirmary's spending on medicine etc. the lowest of all the six hospitals compared in the Animadvertory Letter.[96]

Although the value of good hygiene was not well understood (but might nevertheless have been appreciated - if only for aesthetic reasons) clean linen was seen as a necessity and this was why the writer of the Animadvertory Letter saw fit to defend the outlay on soap so harshly criticised by Edward Garlick.

Wages were a major item but proportionately less than in a modern hospital. In these accounts they can be seen to be responsible for consuming just over 11% of the budget. Matron's salary was £15 per annum with an additional annual gratuity of 5 guineas.[97] The Apothecary received £30.[98] Porters, nurses and washers must therefore have accounted for the remainder, over £200.

Fortunately for the well-being of the finances of the Infirmary the services of the Chaplain came free, his salary of £40 per annum being[99]

> raised by the voluntary Contributions of the Clergy of this City, and the Laity, and any Surplus laid out in proper Books, to be given to the Patients when discharged.

As the Infirmary received money in rents so also it needed to pay out for accommodation which it used but did not own. In both years this necessity required payments of £28 4s 0d.

As noted in Chaper 1, lodgings outside the Infirmary were provided for certain In-patients whose conditions were not too serious, if more room was required for the care of Casualties. No information is given regarding payments for such accommodation in the abstract of accounts (and it is probably not the accommodation referred to in the above paragraph as there is no mention of either food or services being charged for).

Printing and stationery also had to be paid for, £17 6s 0d in 1761 rising to £20 17s 9d the following year.

The 1758 Rules clarified and amended previous Rules governing the demand of 12s 0d from the admitting Subscriber to cover the cost of the funeral of the nominated patient in the event of death or to cover the expense of returning the patient back to his parish upon discharge for those whose normal place of residence was more than ten miles distance from Bristol.[100] By 1758 it had become necessary for the 12s 0d to be deposited only if the patient was in receipt of Poor Relief from any parish more than ten miles distant from Bristol. Generally, relatives removed the body of their dead family member themselves and made all funeral arrangements. Where no family could be identified, or could afford to perform this duty, the burden fell upon the Infirmary authorities. In 1757 the city corporation

granted the Infirmary's request for `a piece of void ground near John Ball's Lane for a burying Place for the Infirmary'[101] and it was in this plot that nearly all the pauper patients and those with no family near at hand (sailors, strangers etc.) who died, were interred. Although the Bristol Infirmary was designated specifically for the `Laborious-Industrious Poor', paupers were admitted from time to time and some of them undoubtedly would have died in the Infirmary. In 1761 the cost to the Infirmary for funerals was £7 1s 11 1/2d. The following year it more than doubled to £16 2s 10d. There is no evidence in the abstracts of accounts of any 12 shillings' deposits being received from Subscribers.

`Casualties', or incidentals as we would now be more likely to call them, were much higher in 1762 than the previous year. We have no itemised details and know only that this term relates to `Incidents not reducible to any of the above Heads'. In 1761 this charge came to £103 19s 7d and in 1762 to £172 2s 3d.

Undoubtedly the budget for the Infirmary was tight, some years desperate, but the writer of the Animadvertory Letter makes his own perceptive comment on this.[102]

> Some men of very good understanding, have said, and do say, that it is absolutely necessary we should be in debt, and charity should always be dependent; for the more she is distressed, the more the good and benevolent are spurred on to assist her, and no greater evil can happen, than for her to be so niggardly, as to refuse doing all the good she can, for the sake of living within bounds, or have such a capital, as to be rendered totally independent.

This is a strategy that was used in the 20th century by voluntary hospitals, in the period before the National Health Service.

The income and expenditure accounts for the Infirmary appear unaffected by considerations of capital

outlay. Nothing is put aside for the purchase of fixed assests or for maintenance, other than items of day to day repair.

The changed value of money makes it very difficult to make commparisons. Are we to look at the price of food, cost of heating, or average daily pay? These have not changed in the same ratio. If comparisons are to be sought between Bristol Infirmary costings and those of modern hospitals all these difficulties have to be taken into consideration. It is a matter for the economic historian.

Some comparisons with St. Peter's Hospital (as the building used by the Corporation of the Poor was known) have been attempted but the two institutions are not easily comparable. In an abstract from the 1769 accounts for St Peter's Hospital (the nearest date to this study of the Infirmary that we have) appears the item `Expenses for provisions and necessaries for the hospital' which amounts to £2,363 1s 11d.[103] The number of inmates, 343, is also given. The amount spent on provisions and necessaries if divided between these 343 persons alone comes to £6 17s 8d per annum, a figure close to that spent per annum on provisioning each Infirmary `bed'. This equation does not take into account any servants but it does include unspecified `necessaries'. However, money spent on burials at St Peter's Hospital was very much higher at £64 10s 2d for the year. Concerning drugs, it is not possible to estimate these, as salaries, medicines, pensions and fees are lumped together in the St Peter's Hospital accounts.

2.4 CONSTRAINTS ON THE POWER OF THE SUBSCRIBERS

A number of points arise from, and shed light on, these financial findings on the power of the Subscribers.

We know that some Subscribers lived outside the city, and these included some whose workplace was within it. Among these, for example, would have been some of the

Subscribers residing in Clifton or Bedminster. If about one quarter of Subscribers lived outside the city (a generous estimate), then about one Bristolian in a hundred, or one elector in fifteen, would have been a Subscriber. (This is proportionately equivalent to 4,500-5,000 in today's Bristol) Thus the Subscribers formed a considerable society, and it is to be expected that the Infirmary assisted social cohesion among them.[104] The annual dinners, associated with annual meetings, were certainly about more than eating.[105]

However, the power of the Subscriber was limited in two ways. When taking their place as House Visitors they were empowered to examine all persons offering themselves as patients to certify that they qualified according to the rules of the Society but it was still the duty of the attending physician or surgeon to examine them concerning their sickness,[106] while Casualties were admitted by the Apothecary with no Subscriber's recommendation. In finance, a limitation of Subscriber's power arises from there having been no mode of financing major captial expenditure out of income. The Infirmary did not borrow, and interest on its invested reserves were such as to yield only about one-tenth of annual outgoings. Any expansion of the work of the Infirmary required either the plundering of invested funds or resort to public fund-raising activities. To be able to raise money from the public, the Subscribers, one may reasonably infer, would have needed to pursue policies consonant with the ideas and principles of a population of donors wider than the body of Subscribers themselves.

Despite these limitations, the Subscribers held effective control until, later in the century, it began to slip into the hands of the surgeons. For about three generations, however, the Infirmary was a citizen hospital with neither ecclesiastical nor academic domination. In this, Bristol Infirmary followed the Westminster Hospital, which the Infirmary's founders had taken as their explicit example.[107]

CHAPTER 3

The exercising of power : attitudes towards patients

3.1 INTRODUCTION

Attention has already been given to the origin of the Bristol Infirmary and the way in which the authority of the Subscribers was exercised in admission of patients and in finance. The relation of the patients to the Subscribers can now be examined, with attention to the evidence for the way in which Subscribers and members of the better-off classes viewed the patients. In this enquiry into attitudes there is no attempt to enter directly into anyone's mind, a dubious enterprise for the social historian, nor are attitudes equated with what people say on the assumption that what one writes is, alone and in itself, a reliable guide to what one thinks. Rather, certain items of behaviour are considered, with some restrictions which they imply about the attitudes that can be presumed to underlie the behaviour.

To enable this behaviour to be interpreted it must be given a context. The general historical and social context has been indicated, especially in Chapter 1. Now some consideration is given to philanthropy as it was practised in Bristol in the early and mid-18th century. Inventories (not previously reported or not examined for clinical implications) and other documents are then used to examine provision for the patients, especially food and the equipping of wards. It will be seen that these could have been less, had the Subscribers no motive other than incarceration, segregation, or control. Hygiene and nutrition appear to accord with medical desiderata.

The Bristol Anniversary Sermons will be considered in some detail and the work reported takes forward in two respects recent research on them by Barry and Fissell.

First, the published references by Barry and Fissell deal with only two Sermons, Reverend Josiah Tucker's (1745 preacher) by both and Reverend Carew Reynell (1738 preacher) by the latter author. As will be seen this only nibbles at the available material and, as will be shown, Tucker's Sermon is atypical. Secondly, the present work takes account of the circumstances in which the Sermons were given, so that certain social inferences become possible. Material from the Sermons and points made in them are given by topics; thus a range of reasons for giving to the Infirmary are presented for the reader's consideration. The main reasons, declared before the patients, are that the only source of the wealth of the rich is the labour of the poor and that the ill health which beggars the poor results from working conditions needed to produce luxuries which the poor themselves are unable to afford. A notion of indebtedness of the rich to the poor, a form of social obligation arguably linking civic duties to the capitalist structure, is thereby underlined.

3.2 PHILANTHROPY AND THE BRISTOL INFIRMARY

Whatever the wider benefits exchanged between patients and Subscribers, within the working of the Infirmary itself the relation of these groups each to the other was quite asymmetrical. The patient was the beneficiary, the Subscriber (and unpaid physician or surgeon) the benefactor. The patient needed the support of the giver, but the giver was free not to give. In the previous chapter the objects of the Infirmary were presented, but their interpretation depends on attitudes. In examining these, it will give perspective if the philanthropy of the period is first briefly reviewed.

Attention will be paid to some of the indications of the attitudes of the donors and of the powerful to the patients, and the evidence will move from the least specific to the most concrete. (See Appendix 1, p.294 for a copy of a curious poem of possible relevance.) First, some comments

will be made on notions of philanthropy in England during and before the period under consideration. Next, reference will be made to the question whether the Infirmary was a method of social control, and finally an account will be given of provision for nursing and medical care, especially the former, together with details of hospital diets and Matron's inventory for 1752.

Traditionally, during the early modern period, private philanthropy came from among the ranks of the merchant aristocracy and gentry. As. W.K. Jordan discusses,[1]

> Men of these classes had come to assume a large and an essentially aristocratic measure of responsibility which very few of their number failed generously to implement as they ordered their affairs towards the close of their lives.

It could be argued that a legacy is a `cast-off' gift, the original owner no longer having any requirment for it. This is not so. A legacy too requires a generous motivation for there is a sense in which `you can take it with you' by giving it to your children or investing it in your business.

By the close of the 16th century this tradition had spread throughout English society and[2]

> to give or leave something to the community - a fund for the poor, an almshouse, a grammar school - came to be expected of the more prosperous Englishmen.

The Red Maids' School in Bristol was founded by Alderman Whitson in just this tradition. A school[3]

> For forty girls, who are uniformly dressed in red cloth jackets, was founded by Alderman Whitson, about the year 1627. They are admitted from eight to ten years of age; and stay in 'till eighteen; and then they receive new cloaths, and are placed out in service. At the school they are provided with lodging, cloathing, and boarding; instructed in reading, in all sorts of white needle-work, and in the doing of household work.

The next century-and-a-half ushered in a new social era, of which the city of Bristol was typical. It was an era which saw the rapid development and expansion of overseas trade and huge increases in the population of cities and towns.

Accompanying these changes came parallel innovations in the practice of philanthropy. No longer was individual giving seen as the answer to another's personal crisis. Indeed, now even the occasional giving of alms to the street beggar was becoming shrouded in apprehension.[4]

> He that *gives Alms to every Man that asketh*, even in the Streets, undoubtedly shows a compassionate Temper;- but does a Mischief to the Publick, and the Beggar too, by fixing him in a Life of Idleness, or worse.

Idleness, at least among the poor, was not a state which the moneyed men of Bristol viewed with pleasure or wished to be seen supporting.[5]

Additionally, it may have been that poverty was now seen as too great and too widespread for indiviual giving to have much impact, while unendowed charities were becoming an ever increasing burden. James Johnson makes this latter point in reference to the Spencer's Alms House in Lewins Mead, Bristol.[6]

> This Alms House was built, about the year 1493, by William Spencer, executor to the will of Wm. Cannings, and out of his residuary effects. Some small donations have been left, by benevolent persons, to this Alms House, but the chief support of the poor who inhabit it, comes from the Poor Rate.

Even when grouped together, the large foundations such as almshouses, schools and charity monies together with small parochial relief measures still left, to judge from evidence of unsuccoured destitution, a large, unfilled need which could only hope to be met by a concerted movement channelling funds from many different, often small, sources

to particular and sponsored ends. Only philanthropic activity which was organised and associated, and therefore able to elicit support from a much wider group than previously available, could hope to address the need effectively. Through such organised measures public appeals could be launched, needs given wider discussion, and moral pressure applied to potential donors. This is not to suggest that organisation or association were unknown before; the Bristol Guilds, for instance, had a long-standing history of charitable activity and as early as 1445 its merchants and mariners combined to establish[7]

> a fraternity to support, within the old hospital of St. Bartholomew, a priest and twelve poor seamen who should pray for those labouring on the sea, or passing to and fro into their port.

In 1735 a unique opportunity for associating and combining in charity arose in Bristol which still left scope for generous, private philanthropy. Reference has already been made to John Elbridge, in his position as a founding member of the Bristol Infirmary and Munro Smith expands on his generosity further.[8]

> It is estimated that he [John Elbridge] spent at least £1,500 on the Institution during the first two years of its existence; he certainly built and furnished a new ward with twelve beds, and appears indeed to have gradually taken the place of the Building and Furnishing Sub-Committee, as evidenced by such entries in the Minute Book as this: "Mr. Elbridge be desired to continue to furnish the Buildings for taking in In-patients and to give directions for the making the Bedsteads," etc.

Here, Elbridge was contributing to a socially organised scheme. In another context, as founder of Elbridge's Charity School, he was active in private philanthropy.[9] However, associated and organised philanthropy was set to became the norm, first supplementing and then surpassing, but never entirely supplanting the older system, even as today we witness direct private benefactions alongside programmed giving through large

registered charities, some of it programmed at the workplace.

What was it that motivated people to give so generously of their money? Any attempt to categorize individual charitable impulses is not feasible but it has been generally taught that such impulses can be considered as falling into one or more of the three categories detailed by Lewis and Williams:[10] 1) economic and patriotic (enlightened selfishness); 2) humanitarian (arising from obvious need for relief and from sentimentality); 3) spiritual.

The 18th century was a mercantile era, and merchants could gain by enlightened selfishness. A large labouring force was necessary to convert the basic raw materials into saleable and usable commodities and a large maritime fleet required to ship the goods around the world. Anything seen to detract from the ability of the workers to perform at their potential peak was both an economic liability and a great annual deficit to the nation. Sickness and poverty reduced the number of effective workers and the mercantilists took to heart the threat in John Beller's warning, published in his essay of 1714, `Towards the Improvement of Physick'.[11]

> Every Able Industrious Labourer, that is capable to have Children, and so Untimely Dies, may be accounted Two Hundred Pound Loss to the Kingdom.

Paternalistic motives, civic pride, public esteem and a desire to perpetuate the family name are to be found in this category of philanthropic giving. Economic and patriotic reasons for philanthropy were advanced in connection with Bristol Infirmary, as will be shown later below.

In Lewis and Williams' second category, the humanitarian, emphasis is placed on the good of humanity rather than any benefit accruing to the giver. Living in

close proximity to the poor, the wealthy could not but be aware of the great distress suffered by many of their fellow-countrymen - in proportion probably larger even than that group which the Founder and General of the Salvation Army, William Booth, was to term the `submerged tenth' of a later generation.[12] In 1688 Gregory King computed that one-fifth of the nation required alms or other relief.[13] Diet, housing, health and general well-being of the poor contrasted too strongly with the well-being of the prosperous to be ignored by the latter. A shared humanity demanded their intervention. As quoted by David Owen, Dr Maddox, founder in 1746 of the Worcester Infirmary, emphasises this point when delivering the Westminster Hospital's Anniversary Sermon in 1739.[14]

> In Minds not inhumanly deprav'd, a strong and powerful Sympathy prevails; one common Sense and Feeling: Nor can Men, without doing Violence to their own Nature, be insensible and untouch'd at the Distress and Misery of their Fellow-Creatures.

The humanitarian principle can also be seen at work in the unalloyed gift when the giving involves personal disincentives as well as the certainty of minimal recognition. Here there is no economic incentive to give a bad gift. Professor Titmuss elaborates on this form of giving in his work on blood donations in his comparison of the U.K., the U.S.A. and U.S.S.R. and underscores the point that in that country where inducements are not offered (the U.K.) are to be found the greatest proportion of blood donors and the most reliable quality of donated blood.[15] The authors of *The Romance of the British Voluntary Hospital Movement* also make the point that sheer philanthropy was the source of much funding of the voluntary hospitals.[16]

> As in medieval days, much of it was no doubt religion, but much of it was also sheer philanthropy unmoved by fear of punishment or hope of reward in another world.

The humanitarian principle, as will be seen, was enunciated in support of Bristol Infirmary.

Lewis and Williams' third category, the spiritual, expressed as the Christian obligation of charity, the `Philanthropy of Piety', has always been an accepted motive for philanthropic activity. However, these two authors differentiate between two different aspects of this type of giving. One they subsume under `Treasure in Heaven' and the other as `Evangelism'.[17] Although the Reformation brought indulgences into contempt, the idea of storing up treasure in heaven through good works on earth still attracted some adherents. There was also the sanction that those who failed to relieve the less fortunate were to be held responsible for any ill to which such may later fall prey.[18]

> He who locks up his iron Heart and iron Chest, and witholds Relief from any Person's languishing and dying for Want, is accessory to that Person's Murder.

Within this third category most altruistic behaviour is best seen in activity and philanthropy which contributed to the salvation of the soul. It was hoped that concern shown through practical ministration for the physical welfare of the poor would lead the poor to a growing awareness of spiritual matters and the beginning of a Christian experience, leading, in time, to their eternal salvation. An echo of this is to be found, years later, in the injunction phrased by William Booth, `No one gets a blessing if they have cold feet, and nobody ever got saved while they had toothache!'[19]

As with William Booth, so with the voluntary hospitals; reform was always secondary to therapy although it was always a looked for goal. Even Winchester, founded by the cleric Alured Clarke, leaves the matter of the reformation of patients to almost the very last of its proposals.[20] Again, in the 1758 printing of the Rules which governed patient behaviour at Bristol it is only the last Rule that paid any attention at all to moral improvement, and then it is a Rule that was permissive, not mandatory, being merely the injunction[21]

> That such In-Patients as are able, be allowed to go to their respective Places of Worship on Sundays in the Forenoon and Afternoon, and that they return to the Infirmary directly.

However, the `spiritual' kind of motivation need be neither pointing heavenward nor evangelising. It can be disinterested, and so converge with some charity arising from a humanitarian motive. `Spiritual' motivation for public giving will be shown to have been accepted as a proper impulse for supporting Bristol Infirmary.

Dating the onset of the application of this philanthropy to the funding of the provincial hospitals, Roy Porter recognises it as an integral part of the fashion of the times, referring to Henry Fielding's words, `Charity is the very characteristic virtue of this time', to support his theory.[22] Alexander Pope, in 1743, wrote in a similar spirit:[23]

> In Faith and Hope the world will disagree,
> But all Mankind's concern is Charity.

The timing of organised and associated charity fits in well with the foundation of the Bristol Infirmary. In the 1730's Bristol society was changing. Trading and manufacturing not only generated a power structure but the wealth of the merchant and manufacturer could be seen to be connected directly to the misery of the very visible poor. While such a connection may have been insufficient to spark shame among the wealthy, it could generate an unease among them. Such an unease would have cried out for salving, and the birth of the voluntary hospital system was able to provide a suitable salve.

The Bristol Infirmary is a paradigmatic example of organised philanthropy. The two guineas contributed by an individual Subscriber might, in itself, have been of minor import but collectively the Subscribers contributed £1,113 in 1761 and £1,098 6s 0d in 1762; a not inconsiderable sum and sufficient, with investment income and small, irregular

donations, to finance the day to day running of the Infirmary and, even as the names of the individual large benefactors survive in the records, so do the names of the two-guinea Subscribers.

Additionally, the two guineas donated annually possessed, for the donor, an advantage lacking in post-mortem gifts; its donors were alive and trusting in God to maintain them in such a healthy state for many years ahead. Far from requiring legal executors to carry out their wishes, or not to carry them out, as the case may be, the Subscribers remained firmly in control, looking with an ever watchful eye for value for money with the sanction of withdrawal of support should they fail to find it.

Since there is some exercise of power by the Subscribers over the patients using the Bristol Infirmary, it is relevant now to note the limits within which this power was exerted.

Although philanthropy was not free of overt self-interest, there is no evidence that patients were coerced into seeking admission to the Infirmary or remaining there once admitted. Whether a Subscriber, in his relationship as an employer ever put pressure on an employee to enter the Infirmary is not known but certain it is that there was no public coercion. Neither did the Infirmary serve any public policy for the removal from city life of those with any specified disease.

The constraint upon the patient was his need for the Infirmary. Though not poor enough to qualify for help from the Corporation of the Poor, he may still have been unable to pay for medical or surgical services or for drugs. For minor ailments there was homely wisdom and therapy but for more serious disease and injury beyond these, only the Infirmary. It was this constraint, and not legally constituted authority, which must surely have been the main source of power exerted in the Infirmary. It is interesting

to remind ourselves how, in this present century, an employer's provision of free or subsidised medical insurance can deter employees from seeking alternative employment in a country such as the United States of America, or more recently, the United Kingdom, even though, in the United Kingdom we still have remaining parts of a National Health Service, paid for from a legally-enforcable contribution from employees and employers and from general taxes.

Sandra Cavallo[24] confirms many of the points discussed here and she writes;

> It has been shown how participation in the management of hospitals and other structures of poor relief favoured the creation of networks of interest allowing the establishment of contacts, business links and influence over work and career opportunities. The post of benefactor or goveror also offered obscure individuals, perhaps excluded from other jobs within the public sphere, the possibility of obtaining and exercising patronage.

Her study of the literature has also led her to the undertanding that[25]

> action to reform the existing system of poor relief and the initiatives which led to the foundation of workhouses and charity schools in many English communities and parishes in the late seventeenth and eighteenth centuries, were heavily motivated by the intention of shifting management of assistance to social and political groups other than those which administered the poor rates or held control of local government.

That the hospital was there to heal the sick Porter[26] has no doubt. He too stresses its function as a social balm whilst still seeing it as `an act of conspicuous, self-congratulatory, stage-managed *noblesse oblige*'. There is room within the philosophy and activity of Bristol Infirmary for all these purposes to find a home.

3.3 BRISTOL INFIRMARY ANNIVERSARY SERMONS

Evidence of the attention towards patient care will now be deduced from the Bristol Infirmary Anniversary Sermons. It will be seen that these throw light on attitudes to the patients especially because they were addressed to benefactors and beneficiaries in the presence of each other.[27]

It was the wish of the original benefactors and Subscribers to the Infirmary to return public thanks to God for the successful setting up of the venture. Accordingly at 10 a.m. on 13th December, 1737 Dean Creswick processed with the Mayor, members of the city corporation, the medical faculty and the Subscribers to the parish church of St James, where, in the presence of the public and the Infirmary patients well enough to attend, he preached a thanksgiving Sermon, following which the Subscribers and invited guests repaired to the Nag's Head in Wine Street for a convivial meal. This occasion marked the first Annual General Meeting of the Bristol Infirmary and apart from changes of dining venue set the pattern for a number of years.

Both Munro Smith[28] and Shelton[29] felt that it should be considered an honour to be invited to deliver the Anniversary Sermon but there are many indications within the recorded Minutes of the period that a number of those invited refused. It seems that while preaching the Anniversary Sermon may well have been a civic honour it carried little ecclesiastical advantage. At times it was the third or even the fourth choice who actually delivered the Sermon. It may be inferred from the printed text of the Sermons that they lasted about a full hour and were delivered in a form which could later be printed as it was the rule of the Society to distribute printed copies to Subscribers, making further copies available for purchase by the general public at the price of 6d each.[30]

Interest in these Sermons arises not only because the preachers were of the economic and social class from which many or most of the Subscribers were drawn but also because the congregation to whom the Sermons were addressed comprised the two classes of people we are most interested in. Within this situation it is to be expected that the preachers' own social attitudes would become apparent. In particular we can learn how the preacher goes about chiding the benefactors in the presence of the beneficiaries. It will be seen that there was no `not-in-front-of-the-servants' attitude.

Printed copies of early Anniversary Sermons still exist for the years 1738, 1743, 1745, 1752, 1755, 1757, 1766 and 1778. All offer insights into the motivations of the Subscribers but the Sermons also offer a good contemporary view of 18th century Bristol concerns and reveal the precepts by which life was ostensibly ordered in this era. As it can be argued that the Sermons were preached *largely* to sympathetic hearers, and that it is safe to assume that many of the Infirmary Subscribers at least, were believing members of either the Established church or Dissenting chapels, to accept the precepts as expounded in the Sermons as being relevant to the time and the people is reasonable. Some of the main points indicating the attitudes of the giving class, with special reference to these attitudes towards the `Laborious-Industrious Poor', will therefore now be considered.

`Enlightened selfishness' in which `fusing the heart of generosity with the brain of utility into practical outlets' occurs[31] is clearly apparent in Reverend Thomas Broughton's Anniversary Sermon of 1752[32] and it speaks more of investment in human capital than it does of common humanity.

> *Hospitals* and *infirmaries* save the Lives of Numbers, who might otherwise perish, to the great Detriment of the Public, by the Loss of so many useful Members of Society. For it is by the Labour

> of the Industrious Poor, that Trade and Commerce, Manufactures and Arts, Agriculture, and Every Other Business, on which depend the Necessaries, the Conveniences, the Comforts, and the Pleasures of Life, are chiefly carried on.

Humanity, though, bespeaks itself in the use to which the Infirmary was to be put. Tucker visualizes the Bristol Infirmary as being able[33]

> To provide a Cure and Remedy for the Maladies and Diseases of the helpless and laborious Poor,

while to promote the Infirmary as a place in which the `Conversion of Unbelievers, and the Reformation of Sinners' could be looked for, would fulfil the spiritual requirements of many of the Subscribers.[34] Eternal comfort could be anticipated in the knowledge that[35]

> by laying out our good Things...our Principle Piety and Benevolence, we secure to ourselves a Reception into *the everlasting Habitations*.

There was a felt need at least to maintain the current population level, with a hope of increase. War, or the fear of war, was ever present. Revd. John Castelman, preacher of the 1743 Sermon, in the year of Dettingen and three years before Culloden, tells us why.[36]

> ...our Enemies, many and potent, Foreign and Domestic, make it necessary to preserve all the Hands, we possibly can, for the publick Service.

Malthus was not published until 1797, and fears of underpopulation with inadequate numbers to defend the homeland from a foreign invasion, or lack of workers to maintain trade and commerce, were much more immediate concerns than fear of over-population. Each worker had both his own value to the State as an item in the workforce, and as the potential parent of children, as suggested by Bellers.[37] Such requirement to maintain numbers was used often and Castelman was only emphasising a commonly held view in his Sermon. How best to preserve endangered life then was of paramount importance and hospitals and

infirmaries were seen as the obvious providers of this service.

How, though, could such a scheme be funded in Bristol? That the cost would be prohibitively high for an individual to shoulder alone was agreed at the outset. In the 1738 Anniversary Sermon Reynall observed,[38]

> No one Man of the most diffusive Benevolence can relieve such numerous, such general Wants.

A need for associated philanthropy was clearly expressed. Come 1778 and the need is still appreciated. Reverend Thomas Johnes suggests that, as the Infirmary is of a public and extensive nature, it requires[39]

> the concurrence and joint contributions of many, in order to carry on a more noble and charitable design, by their joint counsels and endeavours, and with a common purse.

Reynell addressed his pleas for funds not to the rich and wealthy, for of them he says,[40]

> And here it may be thought, I should, in the first Place, address myself to the *Rich* and *Wealthy*, as most capable to promote such an Undertaking. But, as it is often very hard to persuade Men that *they* are so, as some are too *fond*, and others too *shy* of this Imputation, and both these Characters are equally unfriendly to every Proposal, which tends to extort their beloved *Mammon* from them:

Instead he turns to those[41]

> whose happy Condition sets them above the Fear and Apprehension of Want and Poverty: Amongst this Class of People, many, I hope, may be found neither elated with Pride, nor corrupted by Pleasure, nor hardened by Covetousness, to turn away their Eyes from the Face of the Poor, nor stop their Ears to their Complaints.

Reynell knew his fellow Bristolians! Castelman shares Reynell's view of the reluctance of rich Bristolians,[42] a reflection perhaps on the very few members of the aristocracy who subscribed, but when he details those

whom he feels should be contributing he casts his net so widely none seem able to escape the obligation.[43] `True patriots' are his first target.

> To the Infirmary then, all ye Lovers of your Country! conscious that Union is the Strength and Stability of any Nation;-- that the true Patriots are such, as by Acts of real Beneficence evidence their Love to their Countrymen:-- and that it bespeaks real publick Spirit to contribute even a Mite towards the healing, and restoring to the Service of our Country one poor diseased Man.

Reverend John Aylmer (1757 preacher) does not excuse those with only a small `overplus' from contributing.[44]

> Again, it is well worthy of Consideration to those whose Circumstances do not enable them at once to afford sufficient for the Relief of the joint Misery of the Poor, such, I mean, whose Overplus is small, and may not seasonable be able to collect a Number in the same Circumstances with themselves sufficient for a good Work of this Kind, yet a number of such joint Hands will do much good.

Castelman reminds his hearers that all benefaction is open to abuse but private benefaction more so than public,[45]

> It is not to be dissembled, but Abuses are crept into publick and private Benefaction; - but the latter are liable to the greatest, and most common,

and suggests that corporate giving is a major way of avoiding the problem.

Turning now to an economic point, he observes that[46]

> ...if Infirmaries subsisted in every Parish, the Poor Rates would Lessen, together with the Miseries of the Poor: As I am satisfied, the great Burden on this City will soon grow Lighter, nay, I am well assured, it has already been considerably eased thro' the Infirmary.

Of course, there never were going to be Infirmaries in every parish in Bristol but a high correlation of sickness with poverty was also noted by Broughton[47] and by Johnes.[48]

Bristol's prosperity was mercantile, its citizens used to business economies, and they probably recognized a good proposition when they saw one, and those not motivated by humanitarian or religious aspirations might be prevailed upon to support the Infirmary on a purely prudential basis.

Castelman then moves into the political arena and seeks to solicit a `hearty and bountiful Subscription'[49] from those who are indebted to the Government by virtue of various Parliamentary Acts which freed the Bristol ports from certain embargoes and taxes upon imports and exports. The heavenly orientated are reminded that `Alms is a most prevailing Advocate at the Throne of Grace'[50] and the worldly-minded that `Money lodged [in Heaven] will carry the highest Interest, and make the surest Returns'.[51] Merchants are exhorted to give from

> `prudential regard to yourselves, and Gratitude to the Poor; thro' whose Labour, Hazards, and Sickness you acquired your Wealth'.[52]

This tendency to fit charity into a wide social setting culminates in the idea that in sickness we are all one. There was social mobility in the 18th century as in the 20th and a pool of poverty, then as now, which was constantly changing its borders though never actually going away. Social mobility, Reverend John Camplin (1766 preacher) reminds his hearers, also has a down side.[53]

> Property is perpetually shifting hands; some families of ancient renown are daily hasting to decay and ruin, and others emerging from their native obscurity, take place among the rich and honorable ones of the earth. In this constant rotation, 'tis certain that some must be sinking in proportion as others are rising; and from all these considerations, the unavoidable existence of poverty is clear to a demonstration; *we must have the poor always with us*.

Without a large, impoverished population the riches of the wealthy would cease to have either meaning or influence but should any experience excessive guilt about the conditions of the poor, it could be argued that men were ordained to their station by an omniscient God.

Thus the Anniversary Sermons give some indication of views that it was thought might be acceptable to the benefactors. At the same time, as will now be seen, the beneficiaries would hear the benefactors being told that they, the benefactors, were a mixed lot, with respect to generousity of spirit.

Making friends of the `Mammon of Unrighteousness' is a recurring theme in these Sermons (and if the Sermons can be said to share one common, central theme, then this is it).[54]

> `KNOW ALL! That here is the Great, the important Secret-- how a Man may *make to himself Friends of the Mammon of Unrighteousness, that, when he Fails, may receive him into everlasting Habitations.*

The Biblical text on which this idea is based is not easy for a 20th century mind to comprehend. It forms the closing sentence of the parable of The Unjust Steward; the `Mammon of Unrighteousness' being a reference to surplus possessions.[55] While such surplus in itself can be deemed to be unrighteous it can assimilate and acquire virtue if used for a good purpose though, as Fitzymer agrees, it is not recommending the use of dishonest means to attain a good end.[56] As with Christian disciples before them, prudent use of material possessions by the 18th century owner could vouchsafe an eternal reward when mortality was laid aside or Mammon itself exhausted.[57]

> What Unbounded Grace does it bespeak in the Giver, that those very Things we have received should, by being only properly used, *work for us a far more exceeding and eternal Weight of Glory*! yet this we are taught to Hope, thro' the Mediation of those *Friends*, we may *make to ourselves of the Mammon of*

> *Unrighteousness*:--So true it is, that *Alms delivereth from Death.*

For his part Johnes traces history back to pre-Reformation times to castigate the custom of indulgences, seeing this custom as debasing the true charity exhibited by the Apostles and early Christian believers. Although he deplores the custom, yet he has to defend its beneficial effects. What he pleads for now in this post-Reformation era, which has seen the destruction of so many religious houses, is a return to charity as originally practised.[58]

Broughton goes so far as to make eternal happiness obligatory upon charitable activity.[59]

> But especially let us consider, that the Duty of *visiting the Sick* (which, surely, is best perform'd by supplying them with the Means of Health) is expressly required of us by our blessed Master himself; who not only considers this charitable Act as *done to himself* (a Circumstance of Merit, peculiar to the Exercise of Charity towards the Indigent and Distress'd) but has made it a necessary Condition of *inheriting the Kingdom prepared for the Charitable from the Foundation of the World.*

It would be wrong to suggest that charity was dispensed primarily as a safety measure to ensure an advocate for the giver on the Day of Judgement, a type of spiritual investment. However, if doing good to your fellow man was both advantageous to the receiver and of eternal value to yourself, with what greater prudence could you use your surplus wealth?[60]

But Reverend Samuel Seyer (1755 preacher) has a message for those whose benevolence is not sufficiently disinterested, pointing out that if charity is unrefined in respect to God's service then it will terminate in self-love. Self-love being criminal, the charity it dispenses will reap only the applause of man.[61]

> To do our Alms in order to be seen of Men, even when it succeeds according to our wishes, can

> claim only the reward it aims at, the applause of man, *who is a thing of nought, and whose time passeth away as a shadow.*

Johnes makes the plea for the distinction between high and low to be made forfeit during sickness. when the incentive to work is lessened.[62]

> Indeed, in the days of health and strength, it is highly fitting and proper, that the accomodations and conveniences of life, should be proportionate to the *different* ranks and fortunes of men; and the poor should rest satisfied and contented with such, as are within their reach, and suited to the class they hold in the community. But, when they are thrown on a bed of sickness. these distinctions of fortune should be overlooked, *the natural equality* between creatures of the same species should be considered: And the sense of suffering, which cannot but be common to the whole human race, should remind us of our duty, and move us to do every thing we can, to soften the rigours of poverty, and to extend to them all comfort and assistance.

Reynell reminds his hearers that the sick and disadvantaged are not isolated, but that their presence and need is apparent to all who will but observe.[63]

> Let us only look abroad into the *poor* World, and there view the Misery of a Sick Bed, without Cloaths, without Attendance, without Food, without Medicine; let us cast up and estimate the several Articles of this sad calamitous Scene; let us reckon up, how many perish for want of mere Necessaries, how many die for Want of timely Advice, and how many others, by the Ignorance of their Advisers.

Earlier in his Sermon Reynell had referred to man as a social animal who elected to organise himself in societies within which different states are both apparent and necessary.[64] He saw this ordering and placing as part of God's design, and in this he was undoubtedly giving voice to doctrines shared by his listeners, and he was also making a plea for charity based on a shared and common humanity.[65] This shared humanity is one more recurring theme. Castelman also sermonizes on it[66] and the sentiment is echoed by

Seyer who speaks of being `touch'd with a compassionate sense of his brother's misery'[67] and, in turn, is again supported by Aylmer's discussion of the all-embracing attribute of the Fatherhood of God. `The Poor are equally the Object of his Fatherly Kindness and Care, with the Rich'.[68] Thus religious belief turns back to the theme of fellow-feeling and responsibility for each other.

The most telling indicator that the Anniversary Sermons provide of attitudes to patients is the repeated declaration that the benefactors must realise that the source of their wealth is the labour of others.[69]

> The goods of the artificer are (at least in many instances) as necessary to the purchaser as *his money* is to the manufacturer; and what enjoyment could the wealthy have of the greatest affluence without the labour and services of their poorer neighbours? the comforts, yea the necessaries of life, depend on their mutual help and assistance; the work is as needful for one as the wages are for the other.

Perhaps employers should have taken Reynell's plea to heart. In his Sermon he can be heard suggesting that the employers should do something outside the wage packet, a wage packet made up of poverty wages and huge workload.[70]

> Let us put a just Value upon the Benefits we receive from their Labour and Service, and then consider within ourselves. whether the paying them their bare Wages and Hire is a sufficient Recompence.

Camplin draws upon the experience of the merchants vis-a-vis the vagaries of trade. He reminds his hearers how easily they might find themselves penniless and in need.[71]

> The bad success of one voyage may run away with the profits of many former ones; and the most wary tradesman be ruined by the misfortunes or dishonesty of other men, with whom he is necessarily connected.

Reynell raises the issue of moral equity in certain of these trades.[72]

> For if we call to Mind, how much some Trades and Employments impair and exhaust Mens Strength, how some others necessarily produce Disorders and Distempers, as it were certain Consequencies and Effects of the Occupations Men follow; if you reflect upon the dangerous Tools some Men work with, the great Weights others lift, the heavy Burthens others bear; if you consider the Heat and Cold of different Climates, the Hazards of climbing Masts, and spreading and working Sails in stormy and tempestuous Weather, the perpetual Fatigue of a Sea-fairing Life, the Watching of the Nights, and the Labour of the Days; if you are sensible that all these various Employs, so full of Toil and Danger, must be undergone to carry on the Trade, to support the Wealth of this Place, you must be convinced, that the Design of the Infirmary, is an useful and charitable Design, and deserves the Approbation, demands the Encouragement of this great trading City.

Camplin too is disturbed by certain aspects of Bristol's trades, his particular concern being directed towards the luxury market.[73] Part of the luxury market he had in mind may well have been the exotic spices and fruits, the sugar, tea, coffee and tobacco in which the merchants traded, exposing seamen in particular to the peculiar hazards of the sea.

> It may be a matter of doubt whether any trade or employment which is evidently and unavoidably destructive of human health and life, may be deemed an innocent or lawful trade, especially when we consider that those which are conversant about the necessaries of life are not of that number; and that the destructive employments are such as administer rather to the superfluous demands of luxury than to the reasonable calls of nature.

Employers[74] therefore were under a particular and personal obligation to contribute[75] for

> Those who enjoy the profits of such labour, which are generally not of a scanty kind, are under every tie of duty to themselves, to the public, and to the unhappy sufferers, to endeavour to repair the breaches they have made; to alleviate the pains and misery of those who have been the instruments of their prosperity and welfare, and as far as it may be in the power of human means, to restore them to their former health and vigor.

Most Sermons note the obvious, that we are sometimes authors of our own misfortunes, without attacking the poor as a class. But in one Anniversary Sermon (and in only one of the eight studied), there is an outburst blaming the poor and calling for their reform.[76]

> And in sober Truth, with respect to the Morals of the Poor at present, far from exaggerating the Matter, it must be acknowledged, *Times were never worse*. For the lower Class of People are at this Day so far degenerated from what they were in former Times, as to become a Matter of Astonishment, and a Proverb of Reproach. And if we take the Judgment of *Strangers* and *Foreigners* of every other Country, who are certainly the most *unexeceptional Judges* in this respect, we shall find them all agreed, in pronouncing the *common People* of our *populous Cities*, to be the most *abandoned* and *licentious* Wretches upon Earth. Such Brutality and Insolence, such Debauchery and Extravagence, such Idleness, Irreligion, Cursing and Swearing, and Contempt of all Rule and Authority, Human and Divine, do not reign so triumphantly among the Poor, in any other Country, as in ours:- Nor did they ever in ours, 'till of late, in any Degree to what they do at present.

This particular cleric, Tucker, confesses to some surprise that the spiritual aspect of the Infirmary had received such scant attention from preachers of earlier Anniversary Sermons and determines to turn this around. After first congratulating the Infirmary for the `Tendency it has towards retrieving the almost lost Sense of Piety and Virtue among the Poor', he proceeds to acclaim the establishment of voluntary hospitals as being[77]

> so many Schools erected for the Revival and Propagation of Morality and Religion, and as Means that may conduce towards a national Reformation in the common People.

The reason why the common people behaved so badly he was only too happy to outline; it was the ease with which the freedom of the city could be obtained.[78] Birth, apprenticeship, purchase, property holding all led now, as by right, to this coveted station. It was the widening of the franchise through the debasing of the modes of entry

that Tucker found particularly hard to accept.[79] The greater entry into city apprenticeships and Guild membership no longer ensured an exclusive citizenry who had, as Tucker perceived it, been educated up to its privileges. Now this exclusivity was being invaded by a large group of ill-educated, unfavoured men abrogating power which was not theirs as of right.[80]

> But alas! all these noble Privileges and invaluable Blessings, are either in themselves too strong and *excessive* a Potion for their weak Heads to receive, or else *they* are most highly criminal in perverting so rare a Prerogative, peculiar to themselves above other Nations, to serve such bad Ends and Purposes. For so it is, that they turn this their *Liberty* into *Licentiousness*, and seem to put no other Value upon it, than as it affords them a Means of daring to do whatever they ought not, even whatever is *right in their own Eyes*.

Even the enforcement of the law held no terror for this new citizenry, rather did they vaunt their status as freemen either to avoid its full rigour or to show contempt of it.[81]

From the same source, Tucker can be heard damning the poor for their tippling, their frequenting of infamous houses, neglect of the shop and workplace, swearing and cursing, lewd talking and filthy jesting, and for consuming the wages of the week at unlawful pastimes. He castigates their lack of foresight in failing to put a little by each week while saying that unsuccessful demands for higher wages only compounded their distress, implying that it is their discontent and not the failure to get more pay that is the source of the distress. All such failings does Tucker regard as being instrumental in holding the people hostage to poverty. Unsurprisingly when copies of this Sermon were made publicly available Tucker was `hooted by the boys and rabble when next he appeared in the streets.'[82]

Fissell quotes this attack of Tucker on the poor and of his advocacy of the Infirmary as designed to be remedial of the morals of the patients.[83] She then says that `the sermon was sufficiently consonant with the views

of the governors that they had it published'. Minutes dated 6th September, 1743 record that Sermons were always printed at the expense of the Infirmary. Indeed, the Minutes dated 6th January, 1737 refer to the inaugural Sermon preached by the Rev. Dr. Samuel Creswick noting that he `preached an excellent sermon at St. James' Church on the occasion, for which he received the thanks of the society, and was desired to print it'. Apart from Tucker, Reynell is the only one of the preachers cited by Fissell, out of the eight. Fissell nevertheless adduces official support for Tucker's views, from the order to print the Sermon. Of the eight Sermons, seven (including Reynell's) were (and probably the eighth also, only the title page does not carry the usual recommendation) ordered to be printed, confirming that this is not a peculiarity of Tucker's Sermon. Furthermore, had Fissell consulted the other Sermons she would have found that all of them (including Reynell's) shared neither Tucker's condemnation of the poor nor his emphasis on the Infirmary as a remedy for `debauchery', etc.. Fissell says that Tucker makes `no mention of bodily ills'. This is untrue; he makes the care of these the hospital's primary function, but chooses not to pursue the topic on the ground that most other preachers had said much of this, to the neglect of the moral function, which he nevertheless puts second. Thus Tucker himself witnesses against Fissell's argument that the primary purpose of the Infirmary was moral reform.

However, Aylmer does rate such reform highly. He writes,[84]

> A very just Motive this for you to assist, and support the good Work we recommend to you and a very just Foundation for our Claim to your Assistance; especially when you reflect on another great Design which ought always to be consider'd, and attended to in, and may be mightily forwarded by, and reasonably hop'd from, these institutions, viz. the Conversion of Unbelievers, and the Reformation of Sinners,

though he still shows clearly that the primary consideration of the Infirmary Subscribers was not that of reformation or

conversion even though this could reasonably be hoped for. This contradicts the general idea of Fissell when she writes[85]

> Just as the workhouse had educated children in morals, so the Infirmary would fulfill the same function for adults, complementing the Mint [St. Peter's Hospital] and the city's growing numbers of charity schools.

We are led to believe by Castelman that attendance at the Infirmary by clergy, other than the Chaplain, was both regular and frequent.[86]

> The poor Sick are constantly, once a Day, and oftner, if Necessity require, attended *in the Wards* by a Clergyman of good Character.

The reader may speculate about clergymen who were not of good character; it is interesting that Castelman felt the qualification to be necessary.

Even so, Seyer, in a postscript to his Sermon, added a plea for a salary increase for the Infirmary Chaplain on the grounds that as bed numbers had risen so had the Chaplain's workload. Until this time the Bristol clergy had clubbed together to provide an annual honorarium of £20. We know that Seyer's plea did not fall on deaf ears for the 1761 State records a salary of £40 being paid to the Chaplain.

Nevertheless, from the commencement of the `Voluntary Hospital Movement' it was accepted that spiritual healing and education was an integral part of Infirmary or Hospital care. Seyer confirms this.[87]

> The *excellent purposes* of the truly charitable Institution, which we are now assembled to promote, are many and various. The usefulness of INFIRMARIES in general, and the particular advantages arising from the prudent and disinterested Regulation of That established in this City might be enlarged upon;-- that it is so constituted as to be the channel of religious instruction, at the same time that it provides for the cure of bodily diseases.

This notion of the Infirmary as a place of moral education persisted into the 20th century, although a shift in perspective can be identified in more recent times. From being directed solely towards the salvation of the soul of the patient, the Chaplain's office, in which formal preaching and evangelising is still embodied, is now more likely to be directed towards meeting the immediate psychological and emotional needs of the patient and his family. The remit has also been widened to assume Christian leadership for all grades of staff.

Apart from the instruction of surgical and Apothecary's apprentices the Infirmary was not a teaching institution. It was, however, from the start hoped that the Infirmary would advance the healing arts. Whatever future generations might come to think, in contemporary eyes the Infirmary was responsible for much innovative treatment and medical advance. In 1738, scarcely with the beds yet warm, Reynell was advising his hearers to[88]

> ...take Notice of the great Improvements in the Science of Physick, and the several Arts dependent upon it, which we may reasonably expect from this Undertaking.

At no other single place in Bristol were such large numbers of sick gathered together under the concentrated care of a handful of medical advisers and it was assumed, perhaps not unreasonably even if unrealistically, that[89]

> greater Experience must produce greater Knowledge and Certainty, as to the Causes and and Symptoms of Diseases, and greater Knowledge and Certainty must give greater Hopes and Probability of Success.

It was hoped that all classes of society would benefit by this advance.[90]

> A Benefit of which every Body more or less partakes; as the additional Knowledge and Experience these Hospitals have furnish'd; and the great Facility with which others are enlighten'd by these Means, has render'd the Cure of

> numberless Complaints amazingly more easy, and expeditious than cou'd have been thought before.

Some were going to benefit more than others.[91]

> And give me leave to add, that the Rich find a peculiar Interest in the Support of these Foundations, from their Tendency to Improve the Arts of Healing; which none stand more in need of, than the Proprietors of Wealth and Abundance.

It is now possible to review what the Sermons tell us about attitudes to patients. As social documents the Anniversary Sermons have proved themselves a very rich source indeed. They encompass 18th century anxieties concerning the level of population necessary to deflect invasion and maintain the smooth running of the economy. A new style of philanthropy is seen being advocated, moving on from very large benefactions by private individuals to an associated and organised philanthropy eliciting support from as wide a base as possible and relying heavily on `making Friends of the Mammon of Unrighteousness', for such friendship could act as a transformer of all one's wealth where any part of it was diverted to a charitable cause. The obligation of the rich not to be hard-hearted is seen as part of one's patriotism, for *assisting in healing one's* fellow citizens is good for the nation as a *whole, and the* sense of the natural equality of creatures of the same species is all part of the same patriotism. The dependence of the rich upon the labour of the poor and an understanding that it is this very labour which is the source of wealth carries the implication that the rich are the beneficiaries of the poor's suffering and that therefore they have a moral duty to intervene in this suffering.[92] The wretchedness of wages, which should be on the conscience of employers, and the vicious circle between poverty and sickness, is highlighted, with the point being made that if the patient cannot get his sickness relieved he cannot get back to earning a wage and becoming self-supporting again. That fit people are less of a burden on the Poor Rate than sick ones is noted and here an indirect relationship with the

Corporation of the Poor can be observed. What is brought to the reader's attention most forcibly by the Sermons is the appalling conditions under which the vast majority of Bristol's poor laboured; conditions which were accepted because they were assumed to be unchangeable - a necessary if unfortunate adjunct to national prosperity.

In the Sermons the Infirmary is said to be valuable for the moral and religious improvement that it can mediate. This purpose, however, in no Sermon is given precedence over the treatment of sickness and injury. The latter is invariably taken to be the Infirmary's prime function.

Thus it can be seen that the reasons for supporting the Infirmary, which could be publicly stated before both Subscribers and patients, are quite mixed. Apart from Tucker's, the Sermons are often theologically and economically sophisticated. We cannot jump to sweeping generalisations; Bristol life in the 18th century was far too complicated for that. Nevertheless, the presence of certain themes has permitted conclusions.

When the rich were reminded of their indebtedness to the poor, were the latter comforted? Were the poor pleased with what was said of their wages? Did the poor agree that their employment was indeed dangerous? It would be of great interest to know the thoughts, aspirations, fears, and hopes of the sick poor from themselves. This though cannot be. What is clear however is that such considerations were subjects of respectable discussion, and that their presentation was felt more likely to open hands than to send the rich away, disgusted, with closed purses.

3.4 BRISTOL INFIRMARY INVENTORIES

Indications of attitude or indications of care cannot be confined to a discussion of financial or spiritual matters alone, and how the subscribed money is spent can be highly

indicative of attitude. The ways in which the Subscribers' contributions were used and the services they provided will therefore now be discussed.

In the Bristol Infirmary of the 1760's, as at most other times, the central position in nursing was held by the Matron. At the time under consideration the Infirmary's first Matron, Mrs Ann Hughes, was still in office; she vacated her post in 1770, only through the necessity of death.[93] When, in 1763, Mr Edward Garlick extensively criticised the running of the Infirmary, he was faced with the following rejoinder.[94]

> Besides aspersing several worthy Gentlemen belonging to this most excellent and universal charity, you have abused our good matron, by telling the world all is left to servants, &c. &c. &c. which is a most notorious falsehood, for her eye is over the management of every thing that comes within her province....our matron...hath governed the house for 28 years with the best reputation.

The Matron did indeed govern the Infirmary and, in the absence of House Visitors (appointed from among the Subscribers) and medical staff, was without superior. She paid the nurses, servants, Apothecary and Apothecary's assistant. She had charge of the keys and of the nightly closing of the outer gates. She could permit patients to take short walks on weekdays and to go to church on Sunday afternoons. It was Matron's place to ensure that all the patients were back in the wards, and sober, by the correct time. (It was lack of sobriety which later caused this last privilege to be withdrawn!) Hers was the task of checking that delivered goods were of the correct quantity and quality ordered. If infection was inadvertently let in it was Matron who had to find the infected patient a lodging, at the Infirmary's expense, in a nearby house and where attention by the medical staff could be continued.[95]

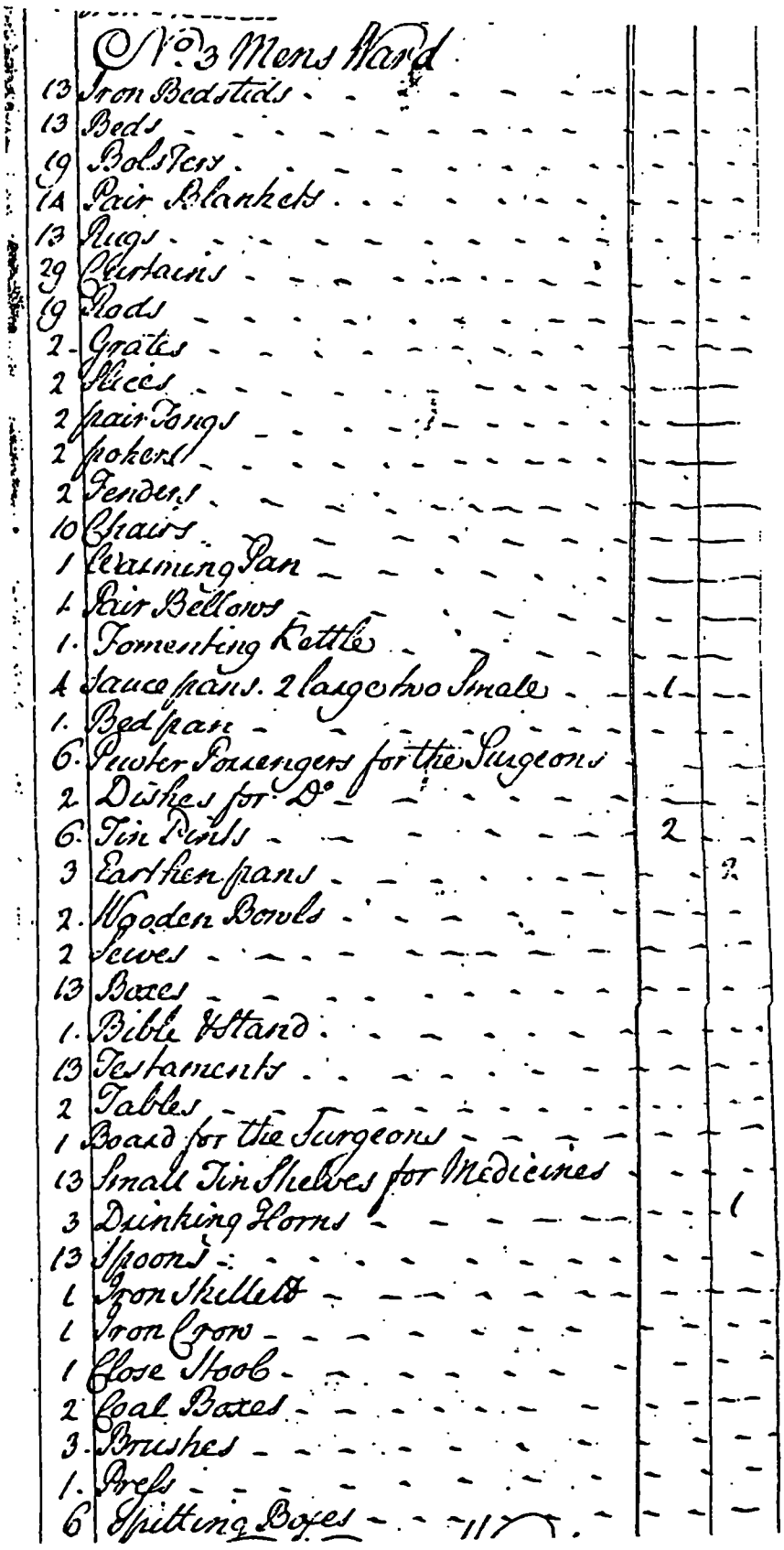
Had the wards been inspected at the time of Matron's 1751 Inventory[96] (see Fig. 3.1, p.135, for a copy

of an extract from this Inventory) we would have found, approximately sufficient for each bed, the following articles: mattress, pair of blankets, rug, two pairs of sheets, a bolster, two curtains with rails, a box for personal belongings, a tin shelf for medicines, a Testament,[97] a towel, and sufficient `Russia towels' to the equivalent of about one for every two beds. A bolster with two pillows suggests that the prevailing attitude was not one directed to imposing punitive austerity on those in need, while the provision of curtains indicate that patients were not held in a contempt which would deny them the dignity demanded by the common decencies. Other ward furniture and furnishings included chairs, tables, coal boxes, warming-pans and saucepans.

One of the most important tasks under Matron's control was the maintenance of hygiene. In this context Edward Garlick complained that more money was spent on soap in Bristol's Infirmary than in Exeter's and the reply to this allegation throws light on the cost of cleanliness generally.[98]

> In the article of soap we exceed *Exeter* about 4L.10s. per ann. and I am much surprised that the difference is so little, especially when we consider the vast number of acute cases that are continually taken into the *Bristol* Infirmary, and in particular, fevers of all kinds, many of them putrid, as well as inflammatory, in which cases the patients being frequently delirious often discharge all their evacuations under them; this occasions a constant supply of clean linen; also the many very bad cases in surgery, which require great quantities of bandages, cloths &c. besides the frequent change of patients more than at *Exeter*, which appears to be 300 and upwards yearly; which circumstances occasion so much washing, that not less than eight people are constantly employed in that work, and these are not sufficient, we being obliged to have washers extraordinary, one, two, or three at a time, to the amount of three hundred and seventy-five days, reckoning three washers in one day, as three days.

The wards were cleaned by seven o'clock in the morning in summer, and by eight in winter. Breakfast was



No 3 Mens Ward

13	Iron Bedsteds			
13	Beds			
19	Bolsters			
14	Pair Blankets			
13	Rugs			
29	Curtains			
19	Rods			
2	Grates			
2	Slices			
2	pair Tongs			
2	pokers			
2	Fenders			
10	Chairs			
1	Steaming Pan			
1	Pair Bellows			
1	Fomenting Kettle			
4	Sauce pans. 2 large two Smale		1	
1	Bed pan			
6	Pewter Porengers for the Surgeons			
2	Dishes for Do			
6	Tin Pints		2	
3	Earthen pans			2
2	Wooden Bowls			
2	Sewes			
13	Boxes			
1	Bible & Stand			
13	Testaments			
2	Tables			
1	Board for the Surgeons			
13	Small Tin Shelves for Medicines			
3	Drinking Horns			1
13	Spoons			
1	Iron Skillet			
1	Iron Crow			
1	Close Stool			
2	Coal Boxes			
3	Brushes			
1	Prefs			
6	Spitting Boxes			

Fig. 3.1 EXTRACT TAKEN FROM MATRON'S INVENTORY, 1751
(The third and fourth righthand columns are headed 'more than last year' and 'less' respectively, in the original document.)

Courtesy of Bristol City Archives

served within one hour of cleaning.[99] From the outset the Infirmary Rules provided for cleaning and nursing assistance by patients.[100]

> That such Patients as are able to work, do assist the Nurses and other Servants in nursing the Patients, washing and ironing the linnen; washing and cleaning the Wards, and in doing such other Business as the Matron shall require.

Extra nurses were employed on a casual basis, as need dictated, and were paid, presumably in addition to their keep, 2s 6d a week.[101] Mothers and near relatives were permitted to help nurse patients, but other assistance was only by leave of the Committee.[102] An exception was made for patients who were `cut for the stone'. An insight into the nursing care of these patients is provided by Munro Smith, although it is improbable that the `Laborious-Industrious Poor' could pay wages for the help they brought in, as Smith's `afford it' requires.[103] Perhaps the nurses were friends or relations accompanying the patient, but not paid.

> A special garret was set apart for these cases, and if the patient could afford it he was allowed to bring his own nurse. Otherwise he came under the care of a woman who by experience had learnt the management of these cases. In the latter part of the eighteenth century the nurse in charge of this department was known by the name of "Old Quiddle".

In the early days, day nurses worked until eleven or twelve o'clock at night and Munro Smith notes that in 1740 only one night nurse was employed.[104] However, by 1765, judging by the Animadvertory Letter which replies to Garlick's charge of extravagance, with special reference to Exeter's thrift, there was a combined total of 26 nurses and servants as compared with 17 at Exeter's. The difference in staffing is stated to be largely due to the Bristol Infirmary's eight night nurses, Exeter having none of these because its Infirmary was for cases of chronic sickness,[105] rather than, as at Bristol, acute sickness.

The 1751 Bristol Infirmary Inventory notes, amongst other items, the contents of the Nurses Room. Listed with the contents of this room are 9 `Iron Bedstids', an increase of 1 over the previous year. In 1740, when there was only one night nurse the Nurses Room was equipped with 1 `Double Bedstid'.[106] Presumably night nurses could sleep at night, working only as the needs of the patients dictated. Only one room was available for the day and night nurses so, presumably, all night nurses were female (as indeed, were probably, day nurses also). Possibly, on the other hand, the nine beds were for day nurses, while the night nurses went home to sleep by day.

Night nursing imposed a financial outlay for more than just nurses as the Animadvertory Letter makes clear.[107]

> BRISTOL, you say, upon an everage of seven years, expends more candles than *Exeter*, to the amount of 25L. 2s. and well it may, the former being obliged to burn candles all night, the latter only upon extraordinary occasions, so that the difference is just as much as burning candle and no candle.---A wonderful discovery indeed! and worthy your pen, to prove what embezzlement, waste, and want of economy we are guilty of.

If the £25 2s 0d is exactly the amount spent on candles for night-nursing, and if we take Munro Smith's note of `good candles at 6/3d. per dozen'[108] (around the year 1737), then night nursing required 80 candles per year, that is, about 3 per fortnight. With 132 beds in 12 wards the candles could not have been left one to a ward, but must have been portable. Had there been one candle per ward it would have needed to last, on average, 55 nights! A further consequence of night-nursing acutely sick patients was that coal fires could not be put out at night.[109] It may be that firelight made it possible to do without a candle, provided that one could be brought as needed, to any particular observation or proceedure.

The nurses need not necessarily have been of the `Sarah Gamp' variety even if Munro Smith does describe them

so.[110]. Of prime importance in any hospital is the level and standard of nursing care provided. The benefits accruing from such care are mostly insusceptible of quantification. Care may be ample or restricted over a wide range without impairing a claim to be helping the patients. Its position on this range in any given instance may indicate how far it is recognised that the healing effects of nursing's applied techniques may be reinforced by those of its implied kindness, the patient benefitting from those unscheduled responses which can be crushed when staffing barely matches, or fails to match, duties.[111]

Food and drink were important in retaining staff. (Fringe benefits as a cheap substitute for wages are not a 20th century innovation.)[112]

> Our day as well as our night nurses must have ale, and live well, or we should not be able to get any to do the disagreeable jobs they are obliged to; it is with great difficulty we can get even what we have, and, in my opinion, nothing but good living (unless they were to have exorbitant wages) would induce them to undertake such a business; for, as I have observed before, there is a vast difference in attending people in acute diseases over what there is in chronical, and, we have room for very few patients in the physical way, except those of the former.

Resident in the Infirmary was the Apothecary, whose work was far more than pharmaceutical. (At that time the apothecary was the healer of first resort outside hospitals also.) He gave medical and surgical attention to patients in the absence of the physician or surgeon. His was the responsibility for keeping the register of patients, as well as for the dispensing of drugs. The first Apothecary, appointed in 1737, received £30 a year,[113] and an assistant, appointed a year later, received £5 per year. The Apothecary's post, being residential but without married quarters, was not open to a married man. Some Subscribers, who were themselves Apothecaries, were appointed visiting Apothecaries and expected to visit the Dispensary

occasionally to reassure the governing body that all was well in that department.[114]

3.5 PATIENTS' DIETS

Material provision as well as human help by nurses and others, just noted, can sometimes give indications of attitudes towards the recipients.

The patients' diets were medically prescribed. There were four variations: common diet, low diet, milk diet and dry diet, but modification could be made to any diet on medical instructions.[115] (Copies of these four diets will be found listed in Appendix 7, pp. 361-2.) Because of the medical prescription of the diet no extra food was allowed to be brought into the Infirmary by the patients' visitors.[116]

The diets listed do not give the full range of foods available to the patients, and the abstract of accounts also itemises the cost of butter, sugar and vegetables. Some of the cooking took place on the the ward, but greens were not to be prepared there![117] There was, however, a hospital kitchen: it is not known how cooking was divided between wards and kitchen. The kitchen is mentioned, and its equipment noted, in Matron's Inventories for 1750 and 1751.

Using the Tables of selected diets given by Drummond and Wilbraham[118] it can be calculated that the average daily energy supplied by the Common Diet would be in the region of 2600 Calories and the protein intake around 70 grams. Thus the Common Diet can be regarded as satisfactory with respect to Calorie value and protein content as recommended by Diem and Lentner.[119] The remaining diets, particularly the `dry diet' with its no alcohol, is open to much doubt unless they were supplemented with other foodstuffs. It is probable that the diet was

better than most patients would have been able to afford for themselves.

3.6 THE CARE GIVEN TO PATIENTS AS AN INDICATOR OF ATTITUDES

Some conclusions on care for patients may now be gathered. The communal organisation of philanthropy did not preclude individual charity but heightened the social function of public giving among the givers. The provision of nursing may have been adequate and the attention to hygiene, especially in delirious or sweating fever patients, indicates conscientiousness rather than any tendency to neglect. It is difficult to evaluate professional staffing from the patient's point of view but it was scarcely perfunctory. As with those serving the patients, so with the latter's diet, there is no sign of skimping, but a strong indication of adequacy. The furnishing and equipment used in the care of each patient shows a proper respect for persons and suggests that patients were subjects rather than objects of charity, human in their own right, not despicable outsiders to whom nothing was due and for whom any gift would have been more than was due.

While Sermons addressed selfish reasons for giving, there is nothing to suggest that Bristol Infirmary was an instrument of direct social control. The Infirmary's Anniversary Sermons show that while patients were expected to be grateful and to show it, it was possible to have the givers listen to explanations, in the presence of the poor, of the derivation of their wealth from the suffering and hardship of those who might become patients in the Infirmary. It seems that such an explanation was believed to result in more giving, rather than in sending the rich away in a huff. We can only guess at the educational effect on the poor of reminding them, with ecclesiastical authority, that their labours were the sources of the wealth of the rich. One would guess that they had already suspected as much!

In summing up the attitudes of those with power it seems fair to say that self-interest, even if enlightened self-interest, must have been present. Nevertheless, there was evident respect for the humanity of those dominated, and it is straining to explain the behaviour of the Subscribers without taking into account the possibility of altrusim and action actuated by the publicised moral principles of the time.

Fissell's point that care for the sick in the Infirmary is like that provided by the Corporation of the Poor[120] is irrelevant unless the relevant features of the care in each of them are specified. In this connection it may be worth remembering that a workhouse in 1696 or 1761 is not necessarily the same in purpose, management, or human and material provisioning, as a workhouse in 1840. From preliminary study of provision for paupers by the Bristol Corporation of the Poor, it appears that the early 18th century Bristol workhouse was different from the traditional view of its 19th century successor in important respects.[121]

A Rule of 1779, probably confirming existing practice, provides a closing comment to this chapter. A group of Subscribers, functioning as House Visitors, were detailed to visit the wards regularly to hear patients' complaints. While they were present, all nurses and servants had to withdraw from the ward.[122] Complaints were to be made in private.[123]

PART II

PATIENTS IN THE INFIRMARY

CHAPTER 4

Places of origin and distempers suffered

4.1 INTRODUCTION

In the first part of this thesis attention was paid to the social context and establishment of authority in Bristol Infirmary, and the exercise of that authority by the Subscribers. It was seen that the Infirmary was intended primarily, if not exclusively, as an acute hospital for the wage-earning poor. In an examination of some ways in which authority was exercised note was taken of the pathways by which the sick gained admission to the Infirmary. When attitudes to patients were considered, provision for the patients was taken into account, this provision having obvious implications for the therapeutic effects of bed rest, comfort, warmth, food, and respect for the patient within a framework of the decencies of life. Thus an examination of some activities of Subscribers has brought to light aspects of the life of the patients, the central concern of this study.

Enquiry into the circumstances and conditions of patients is continued in this second part of the thesis, which deals with matters exclusively in relation to them. The matters to be dealt with are at the heart of the Infirmary enterprise: the distempers from which the patients suffered, the treatment which they received, and the efficacy of the treatment. Part II falls into two chapters. Chapter 4 reviews and comments on the places of origin of the patients and on the distempers from which the patients suffered. Chapter 5 deals with treatment and its outcomes,

which include the outcomes of being in hospital as well as directed interventions.

Inevitably, this present chapter depends upon the Admission Registers (for a critical discussion of which see Appendix 1, pp.279-290) which yield information, the abundance of which poses a dilemma in presentation. To help solve this problem much of the data has been collated into Tables or Charts and these will be found either within the text of the chapter or at its end.

4.2 PATIENTS AND THEIR PLACES OF ORIGIN

The patient's story begins with the felt need for the Infirmary, and of their admission to it. Of the 3402 entries in the two relevant Registers 1015 (29.8%) concerned In-patients and 2387 (70.2%) Out-patients, - a ratio of 2.4:1 in favour of Out-patients. Proportionately fewer female than male patients were treated as In-patients; 409 females to 606 males, a female-to-male ratio of 1 to 1.5, but the reverse can be seen in the Out-patient statistics. Here, females numbered 1,300 and males 1087, giving a female to male ratio of 1.2:1. These figures are set out below in tabular form.

Fig. 4.1 ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, BY SEX OF PATIENT

ADMISSIONS			
SEX OF PATIENT	IN-PATIENTS	OUT-PATIENTS	TOTAL
FEMALE	409	1300	1709
MALE	606	1087	1693
TOTAL	1015	2387	3402

The area covered by the Infirmary's services (unlike those of the Corporation of the Poor) knew no geographical boundary, although by virtue of its position in the heart of England's second most populous city much of its take-up was also inevitably from within the city itself, thinning out as distance increased. The following chart (Fig. 4.2, p.145,) sets out the zones of origin from which the patients came. (Appendix 3, p.307-11 contains details of the coding used for patients' place of origin.)

St. James, together with its expanding out-parish, formed both the largest of Bristol parishes and its most populous.[1] It was also the parish of the Infirmary itself. From this parish alone came 23% of In-patients and 23.7% of Out-patients. Other city parishes (Appendix 2, map 2, p.303) contributed 45.3% of the total In-patients and 62.2% of the Out-patients. Patients with no named origin (Zone 6---) accounted for 5.2% and 0.5% respectively. Places outside the city but within 3-4 miles of Bristol Bridge (maps 3 & 4, pp.304-5) accounted for only 12.8% and 9.6% respectively. A further decrease in admissions can be seen arising from the neighbouring counties (map 5, p.306), 12.4% of In-patients and 3.7% of Out-patients. Areas even further afield, as would be expected, contributed few patients to the Infirmary's care, just 1.3% of In-patients and 0.3% of Out-patients. (Zone 6---is not a geographical allocation but a group of `soldiers', negroes', `Swedes', `strangers', `foreigners', etc., for whom no name of parish is given. This group of patients is deemed, for the present purpose, to originate from within the city boundary, unless the contrary is indicated.)

Most of the In-patients admitted from zones 4---and 5--- had illnesses of long standing duration, as exemplified by Wm. Day of Stratford-on-Avon.[2] He was suffering from `eruption of several years standing all over the body' but was fortunate enough to be discharged `Cured' after three months of care.

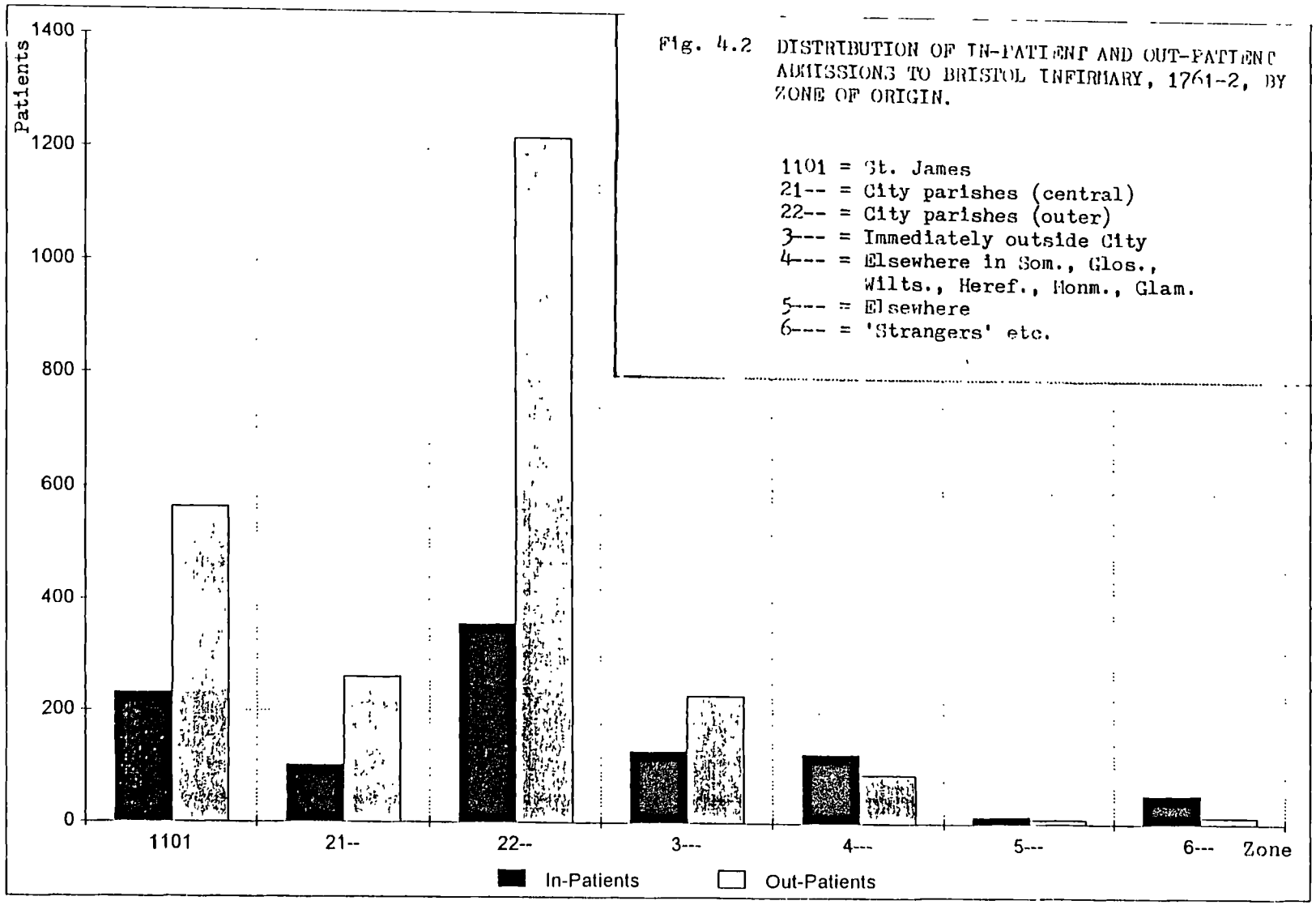


Fig. 4.2 DISTRIBUTION OF IN-PATIENT AND OUT-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, BY ZONE OF ORIGIN.

1101 = St. James
21-- = City parishes (central)
22-- = City parishes (outer)
3--- = Immediately outside City
4--- = Elsewhere in Som., Glos., Wilts., Heref., Monm., Glam.
5--- = Elsewhere
6--- = 'Strangers' etc.

How many, if any, of those from zones 4--- and 5--- actually came to Bristol to take advantage of the care available is unknown. However, it is probable that one with a distemper as serious as that of Thomas Atkins[3] from Ilfracombe, Devon, might expressly journey to Bristol for the purpose of gaining admission. His pathology was a white swelling on the knee and he was discharged four weeks later with his condition `Relieved' but not `Cured'. This condition, innocuous though it sounds, may have been tuberculous arthritis, and could, therefore, have been life threatening. It is discussed in sombre terms in the Edinburgh Medical and Physical Dictionary of 1807.[4]

The journey from outlying areas must have been daunting even for the well and, it can be assumed, only undertaken as a very last resort by the ill. Other Infirmaries were closer to home for some of Bristol's patients. The 2 patients from Hereford would surely have found either Worcester Infirmary or Gloucester Infirmary easier of access and Ilfracombe and Helston were certainly closer to the Exeter Infirmary than to its Bristol counterpart although, in the case of the Ilfracombe admission, the journey by water along the south coast of the Bristol channel to Bristol may have been easier to bear than the arduous overland journey to Exeter.[5]

There is supporting statistical evidence that, for the year under review, proportionately more patients came from outer areas with serious conditions than did so from areas in, or near to, the city of Bristol. Out of a total of 139 In-patients from zones 4--- and 5---, 8 patients (5.8%) had the description `cancer' or `cancerous' noted in their distemper. Only 3 patients (0.3%) out of a total of 876 were admitted with such a diagnosis from the geographically closer areas of zones 1---, 21--, 22--, 3--- together with the descriptive `zone' of 6--- Similarly, where caries of a bone was diagnosed, the outer area had 9 admissions (6.5%) and the inner area 16 (1.8%). Alternatively, potentially chronic ailments were less often

admitted from zones 4---and 5---. Rheumatism, for example, brought about the admission of 4 (2.9%) patients from zone 4--- and none from zone 5--- but 56 (6.4%), came from zones 1101, 21--, 22--, 3--- and 6--- together.

Once admitted, the length of stay was greater amongst outlying patients than their local counterparts, 62.8 days as compared with 45.7. This characteristic held good even for the same distemper. For example, the average length of stay for patients admitted with an ulcerated leg was 63 days from the outlying regions but only 53.6 from zones 1101, 2---, 3--- and 6---. Proportionally more than twice as many 4--- and 5--- zone patients became 'overtimers' than for the other zones, 20.9% and 10.9% respectively. (See Fig. 4.3 below for a numerical display of these findings.)

Fig. 4.3 COMPARISON OF LENGTHS OF STAY, IN DAYS, OF IN-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, ACCORDING TO DISTANCE OF ORIGIN

		ZONES	
PATIENTS		LOCAL ZONES 1101,21--,22-- 3---, 6---	DISTANT ZONES 4---, 5---
ALL PATIENTS	(Number of pts.*	873.0**	138.0***
	(Average stay	45.7	62.8
	(Median stay	35.0	45.5
'OVERTIME' PATIENTS ONLY	(Number of pts.	95.0	29.0
	(Average stay	133.3	156.7
	(Median stay	102.0	135.0

*1011 patients **No length of stay given for 3 patients.
***No length of stay given for 1 patient.
The apparent tendency of distant patients to stay in longer could be accounted for by several factors including differences in the proportions of different types of distempers and unascertainable attitudes to time of discharge. (See Section 4.4, p.168 for a discussion of Mary Fissell's findings on length of stay.)

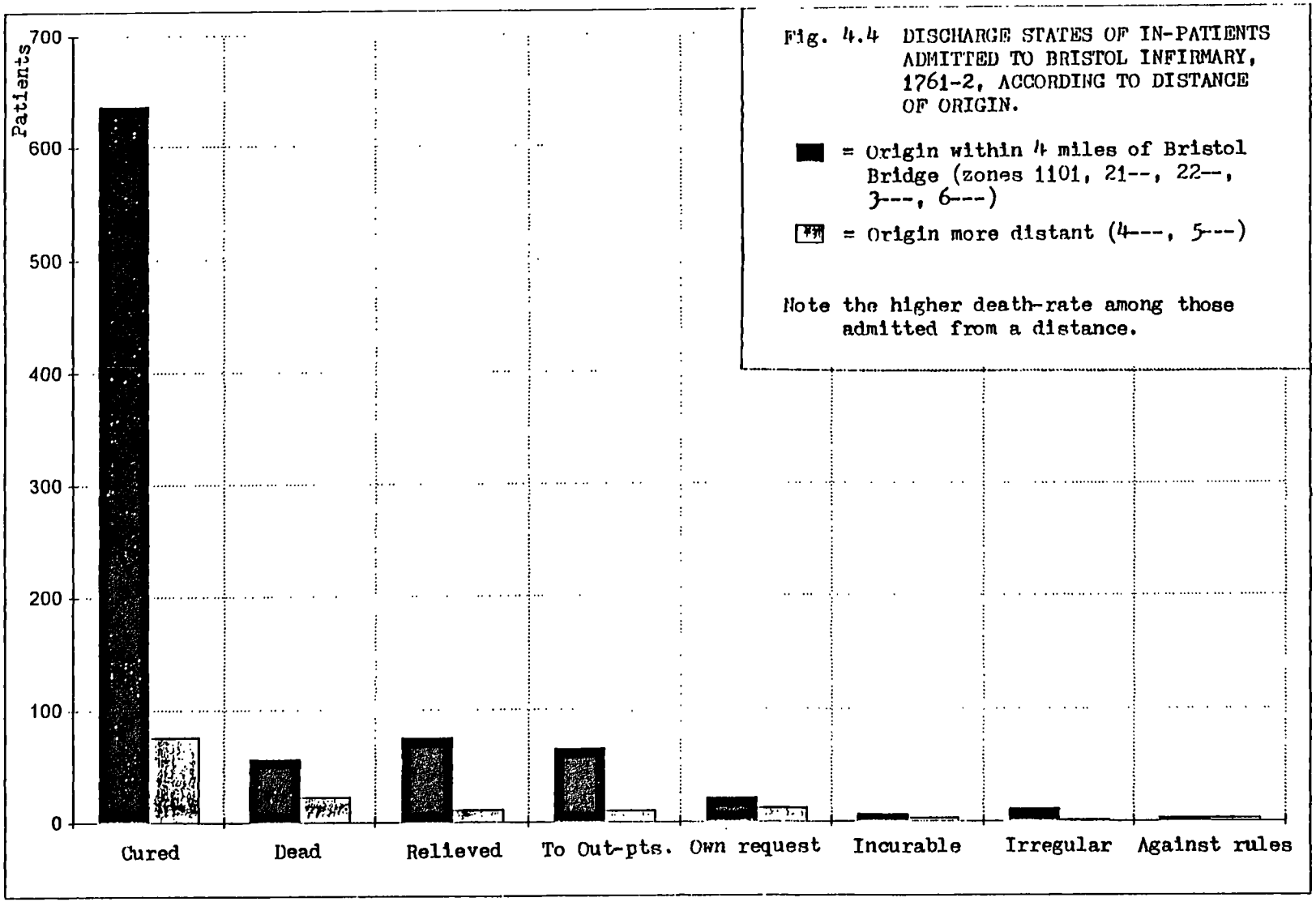


Fig. 4.4 DISCHARGE STATES OF IN-PATIENTS ADMITTED TO BRISTOL INFIRMARY, 1761-2, ACCORDING TO DISTANCE OF ORIGIN.

■ = Origin within 4 miles of Bristol Bridge (zones 1101, 21--, 22--, 3---, 6---)

▨ = Origin more distant (4---, 5---)

Note the higher death-rate among those admitted from a distance.

The rate for leaving the Infirmary with a poor outcome was also higher among the outliers than among their more local counterparts, with a corresponding fall in the 'cure' rate. These patients also took their own discharge more often. However, they were slightly better behaved! Only 1 was turned out for irregular behaviour while 11 were thus discharged from the more local area! Fig. 4.4 (p.148) sets out the state on discharge for all patients more fully.

Clues to these discharge characteristics may perhaps lie in the following considerations. The cure rate may have been inversely related to distance travelled as a result of the patient delaying admission until all local help had been exhausted. Meanwhile the malady would almost certainly have worsened and the consequent chance of a cure diminished. This same theory could explain the higher 'Relieved' discharge state. The lower death rate may reflect the same philosophy - only now the potential patient who would have died in hospital never arrived there because the distance to be travelled acted as a deterrent until it was too late and death intervened. In general, distance requires need and hope. The discharge rate to Out-patients from these outliers is a surprising finding. At 7.2% (10 patients) it is closely related to the local zones' rate of 7.4% (65 patients) but whereas Out-patient attendance would be a feasibility for most local people it would be almost out of the question for those living at a distance unless, of course, they lodged in Bristol until final discharge. The author of this work has no evidence that either inns or other lodgings were found for these patients by the Infirmary. It may be that discharge to Out-patients was a way of letting the patient return to the Infirmary, if and when desired, without repeating the obtaining of a Subscriber's letter. Direct admission to the Infirmary as an Out-patient from zones 4--- and 5--- accounted for only 4% (96 patients) of Out-patients, leaving the other 96% (2289 patients) to come from more local areas.[6]

We shall now see how the Admission Registers indicate, for each patient, the route of entry to Infirmary care, either admission as a `Casualty' (being available for In-patient care only) or by named Subscriber nomination. Additionally an occasional indication of whether the patient was transferred between In- and Out-patient services is given.

4.3 CASUALTY ADMISSION

The nomination system was inappropriate for Casualties, whose need for attention was immediate, and the standing Rules of the Infirmary allowed for this frequent occurence by investing in the Apothecary authority to admit emergencies on his own decision but with the proviso that he immediately inform the physician or surgeon of the week of his action. The medical conditions of the Casualty patients are what one might expect to meet in such an institution and a breakdown of all conditions is listed in Fig. 4.5, below.

Fig. 4.5 DISTEMPERS AFFECTING CASUALTY ADMISSIONS TO BRISTOL INFIRMARY, 1761-2. (A patient with more than 1 distemper is counted here under the most severe.)

MEDICAL CONDITION	NO. OF PATIENTS
No record	1
Fractures	44
Compound fractures	4
Dislocations	4
Sprains	11
Burns	2
Scalds	3
Woundings, contusions, lacerations	61
Gunshot wounds	5
Concussion	1
Ulcer of the leg	2
Gangrene of the leg	1
Scrofula	1

All but four of the patients could well be bona-fide Casualty patients, in the light of the use of the term at the Bristol Infirmary at the time, and of the conditions themselves.

Fig. 4.6 SOME OF THE DISTEMPERS AFFECTING CASUALTY ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, IN THE WORDS RECORDED IN THE ADMISSION REGISTER

Fracture of the skull Trephined
Fracture of the skull Trephined in two places
Fracture of the cranium and torn fracture of the leg
Fracture of the leg Seized with smallpox
Dislocation of the shoulder and impostumation of the lungs
Sprain of the back legs and arms
Fell in to a furnace of boiling lees
Contusion of the head and back and fractured skull
Contusion of the back Seized with smallpox
A bank of rubble fell on him. Back and breast violently contused
Cut his foot by a glass bottle
A tendon and artery of the left hand divided. Seized with the Measles
Struck a pickax into his foot
Fell upon the prong of a pike
The yard of a ship fell upon his breast
Fell from the top of a house 40 foot high and shocked the brain with a contused thigh
Gunshot wound of the neck with a piece of scapula broken off
Gunshot wound of the thigh
Gunshot wound of the ankle
Gunshot wound of the arm and hand
Gunshot wound of the hand
Burnt all the body, arms and legs
Burnt legs, arms, breast and face

The exclusion of children under the age of seven years has already been discussed. Of the 11 young children who were admitted as In-patients 6 came as Casualties. Amongst these 6 is the case to be found listed in Fig. 4.6 above, of burns to the body, arms and legs. In spite of the seeming severity of these injuries this four-year-old boy was discharged home `Cured' after only six days hospitalisation. Not so fortunate was the other child

patient with extensive burns and whose condition is the last listed in Fig. 4.6. This four-year-old girl was held in the Infirmary for six months before being discharged, also as `Cured'.

On the whole, burns and scalds did not figure as largely as one might expect, given the domestic overcrowding, use of open fires for both warmth and cooking and the general inconvenience of the homes of the poor. Perhaps domestic treatment was widely known, and, maybe, used to good effect. Although the 2 children referred to above most probably received their burn injuries in the home, the fall of an adult into the furnace of boiling lees (a strongly alkaline solution used in the manufacture of soap) was certainly an industrial accident.

All of the 5 gunshot woundings involved males in either their late teens or twenties. Of these 5 woundings 3 involved sailors. It should be remembered that Bristol was the country's second port. Perhaps these were naval sailors whose ship's surgeons had done their best and then directed the patient to Bristol Infirmary. Perhaps they were battle wounds? It should be remembered that the Seven Year's War, 1756-1763, was still taking place at this time.

The list of conditions and the numbers suffering from them hide many personal details. It is the individual event which defined life for the patient, then as now, and as it sometimes defined death.

The day of admission to the Infirmary as a Casualty (see Fig. 4.7, p.153) is of interest, particularly when compared with the day of admission of Subscriber-recommended In-patients.

It was the Apothecary who was responsible for maintaining the Register but he does not appear to have done so on a daily basis, for it is unlikely that

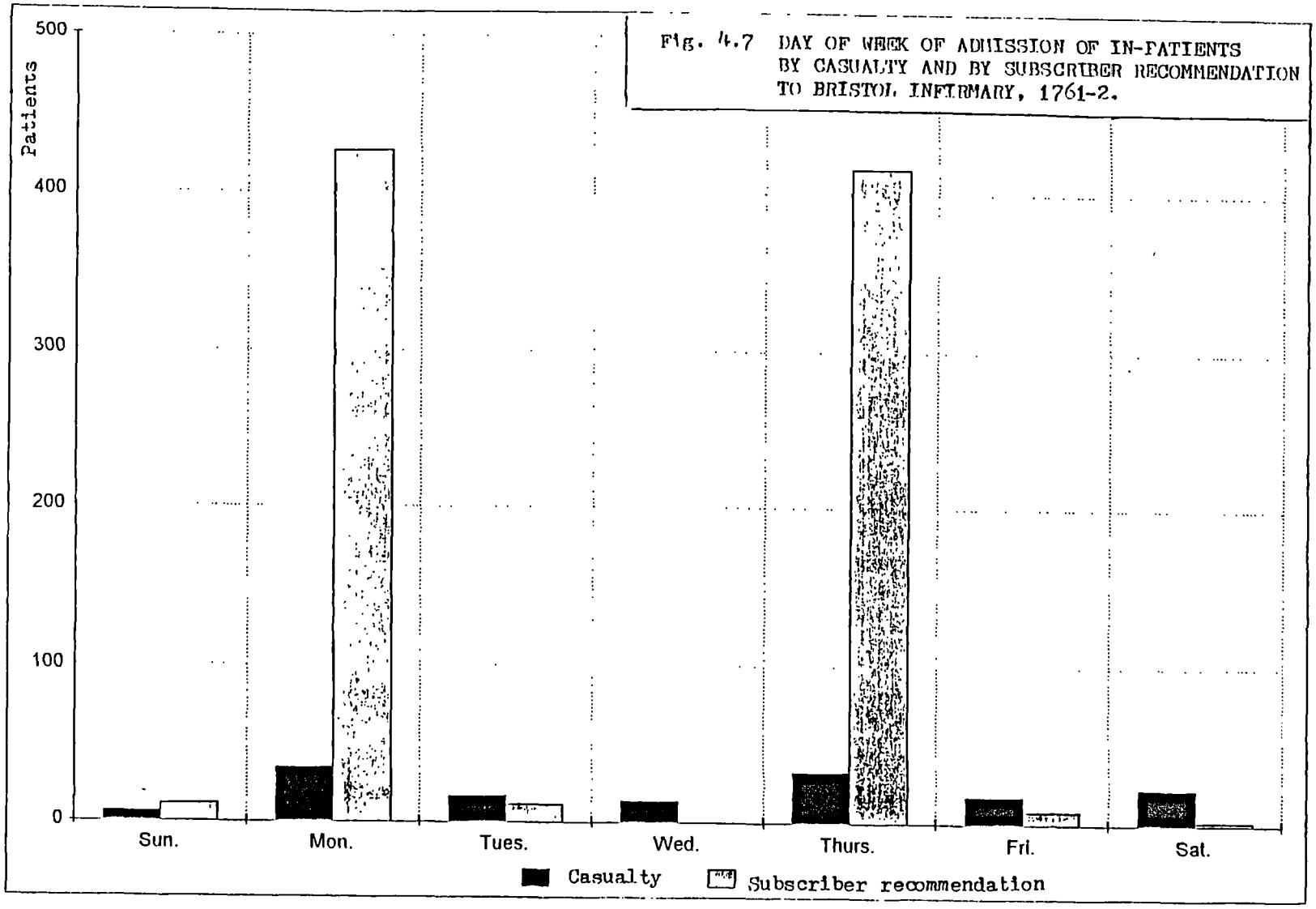


Fig. 4.7 DAY OF WEEK OF ADMISSION OF IN-PATIENTS BY CASUALTY AND BY SUBSCRIBER RECOMMENDATION TO BRISTOL INFIRMARY, 1761-2.
Patients
500
400
300
200
100
0
Sun.
Mon.
Tues.
Wed.
Thurs.
Fri.
Sat.
Casualty
Subscriber recommendation

Mondays and Thursdays would account for nearly half (47.1%) of Casualties admitted. It is more likely, as these were the days when the House Visitors would visit, that the Register was brought up to date for these occasions. For Subscriber admission, Mondays and Thursdays, the days when the Committee admitted, together accounted for 96.3% of the total. The low Sunday percentage may support the fact that Casualties were often victims of workplace accidents. The distribution of Casualty admission over the other four days has an acceptable realism. The thirteen Casualty admissions on Wednesdays confirm their independence of the admitting committee; no Subscriber-nominated patient was admitted on a Wednesday for the entire year under consideration.

The female patients admitted as Casualties numbered only 22 - just 15.7% of the total. This is a very different proportion to those In-patients admitted by Subscribers where the female rate was 44.2% (387 patients). If one has in mind the type of conditions admitted as Casualties, the higher male rate reinforces the supposition that many of the injuries were related to work. That the workplace was not a healthy environment the Reverend Josiah Tucker observed, (as also did Reynell; see the quotation from Reynell on p. 124) when, in a Sermon preached on 18th March, 1745, he discussed the motives of the contributors to the Bristol Infirmary, making this point.[7]

> `Or is it perhaps a Principle of *Justice* and *Equity*, that affects us most;- a Sense, that it is *fitting* and *right* to return something to the Poor by way of *Compensation* for the Inequality of our Possessions, and of making some *Reparation* for the Injuries thay may have suffered, and the Diseases *contracted*, when drudging on *our* Account.

The discharge state of Casualty patients varies, in certain respects considerably, from Subscriber nominated patients but this is a reflection of the presenting condition more than anything else. Generally speaking, and not surprisingly, of all the conditions presenting at the Infirmary, soft part injuries were the most likely to result

in a complete cure and this was the most common type of injury among Casualty admsissions, accounting for 61.4% (86 patients). In other In-patient admssions soft part injuries accounted for only 10.6% (93 patients). A cure rate among Casualties then of 90.7% is not surprising especially since these injuries were often contusions or simple woundings (over 40 cases of contusions and 10 of lacerations were admitted as Casualties in this year.)

Only 1 Casualty patient was discharged as `Relieved', a young woman with contusions to her back.[8] It is impossible to know now whether the cause of these contusions was an accident or a deliberate human act.

As soft part injuries often resulted in a good cure rate, so similarly they accounted for a low transfer to Out-patients. Such follow-up after discharge from the wards was considered necessary in only 2 cases; the patient admitted with scrophula[9], who probably cannot be described as a `Casualty' anyway, and the man suffering from a lacerated wound of the head.[10] This last injury was probably fairly superficial as the patient was warded for only 6 days.

Although soft part injuries have been shown to have a good cure rate and this skews the discharge states to the favourable one of `Cured', there were some deaths among Casualty patients, though not all from the conditions for which they were admitted. Two of the patients with injuries normally found to be non-fatal probably died of an intercurrent infectious disease which they were either admitted with or acquired after admission. To be more precise, a stranger admitted with a hand injury and noted as being `seized with the Measles' died after 28 days[11] and a patient with contusions to the back who was `seized with smallpox' died 12 days after admission.[12]

Bad accidents were the precipitating factor in the deaths of 4 patients; 1 fell from the roof of a 40-foot high

house,[13] one had a bank of rubble fall on him,[14] a third fell into a furnace of boiling lees[15] and a fourth contused his breast when he also had a fall. All these mishaps were potentially, and, in these instances, actually, fatal. The death of another patient, suffering the double distemper of *a dislocated shoulder and impostumation* of the lungs[16] in *all probability died from* the lung condition and not the *dislocated* shoulder. Again, impostumation, a collection of matter or pus, was not properly a Casualty problem.

It is of note that no Casualty admission took their own discharge, something that 33 Subscriber nominees did, nor were any of the Casualties discharged with the prognosis of `Incurable'.

The case of scrophula is a surprising find in a Casualty admission, as are the 2 cases of leg ulcers, although any of the three could give rise to an emergency. The single case of gangrene of the leg might also be more properly the province of Subscriber nomination.

To sum up, there is very little evidence to suggest that Casualty was used to by-pass the more formal Subscriber recommendation route. Neither does it appear that the system was otherwise manipulated by its users. Those under seven years of age presented with emergencies which it would have been very diffcult to refuse and the same is the case for the few moribund patients. No-one was admitted through the Casualty service and discharged as being admitted contrary to the Rules.

Both modes of entry to the wards as an In-patient, directly as a Casualty or by Subscriber nomination, had their own place and own value in the scheme of the Infirmary. Had either strand of this bipartite system been missing, the work of the Infirmary would have been fragmented; joined together they allowed a cohesive and comprehensive healing system to be delivered to the `Laborious-Industrious Poor'. The Register reveals Bristol

Infirmary to be an acute hospital able to receive, in addition to general medical cases, a wide variety of surgical emergencies.

4.4 PATIENTS AND THEIR DISTEMPERS

The epidemiological pattern emerging from the combined study of distemper and seasonality with the area of origin of patients, will be discussed first. (Figs. 4.8 to 4.13, pp.158-162, inclusive are graphical displays relative to this section. The full epidemiological details of all patients, that is the distempers suffered, seasonality of distempers and zone of origin, will be found in Appendix 8, pp.363-80.)

Figs. 4.8 and 4.9 indicate the number of admissions according to the first-named (and almost invariably most severe) distemper while the geographical locations of patients in relation to all distempers suffered is displayed in Figs. 4.10 and 4.11. Figs. 4.12 and 4.13 illustrate how the number of admissions varied over the twelve months. (In order to equalize the periods, 13 four-week periods have been taken instead of the 12 calendar months.) It is important at this juncture to note that the potential of Out-patient admissions is in principle sufficiently extensible to cope with demand and is limited only by its perceived usefulness to patients; there is no restriction due to lack of beds. (The increase in Out-patient admission in early summer is largely explained by the number of patients being referred with `cough'.) On the other hand, In-patients are filling a limited number of available beds, so that the number of admissions may not be so sensitive to demand. As noted in Chapter 1 there were, in 1762, 386 patients turned away for lack of room. The previous year 362 people were similarly disappointed.

Bone injuries (Group A) The predominant feature of bone

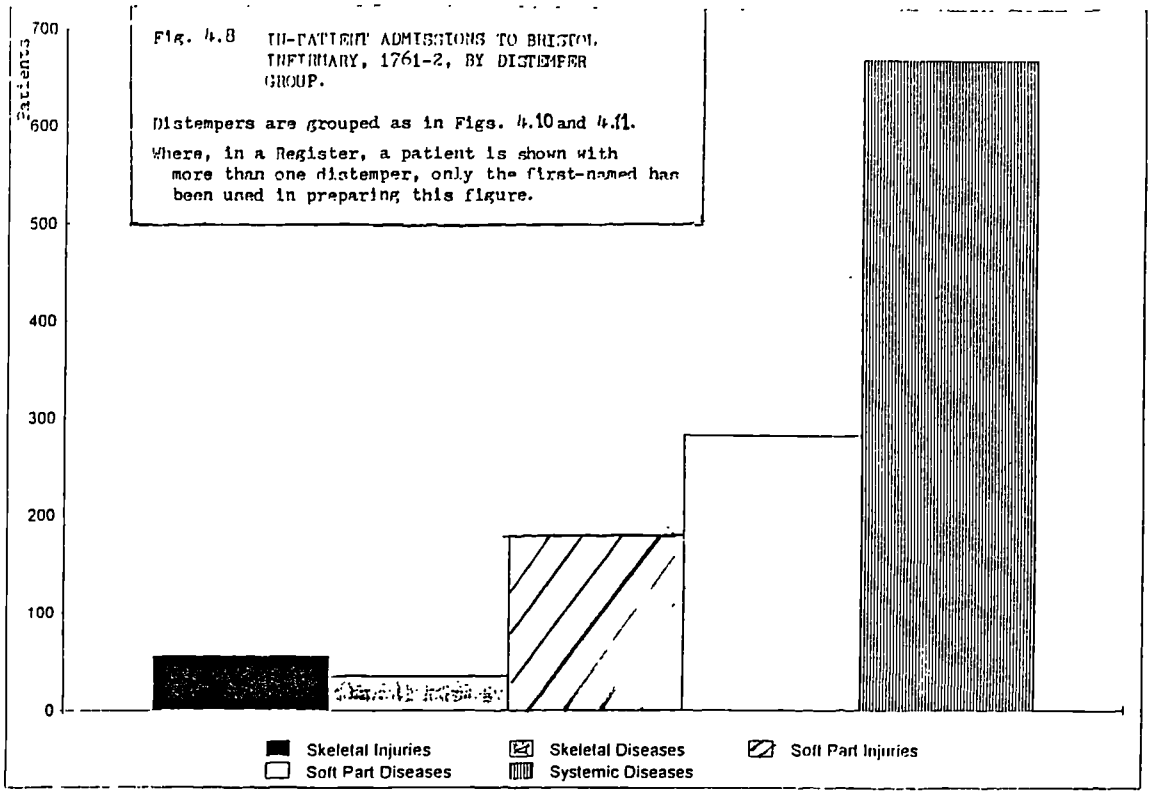


Fig. 4.8 IN-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, BY DISTEMPER GROUP.

Distempers are grouped as in Figs. 4.10 and 4.11.

Where, in a Register, a patient is shown with more than one distemper, only the first-named has been used in preparing this figure.

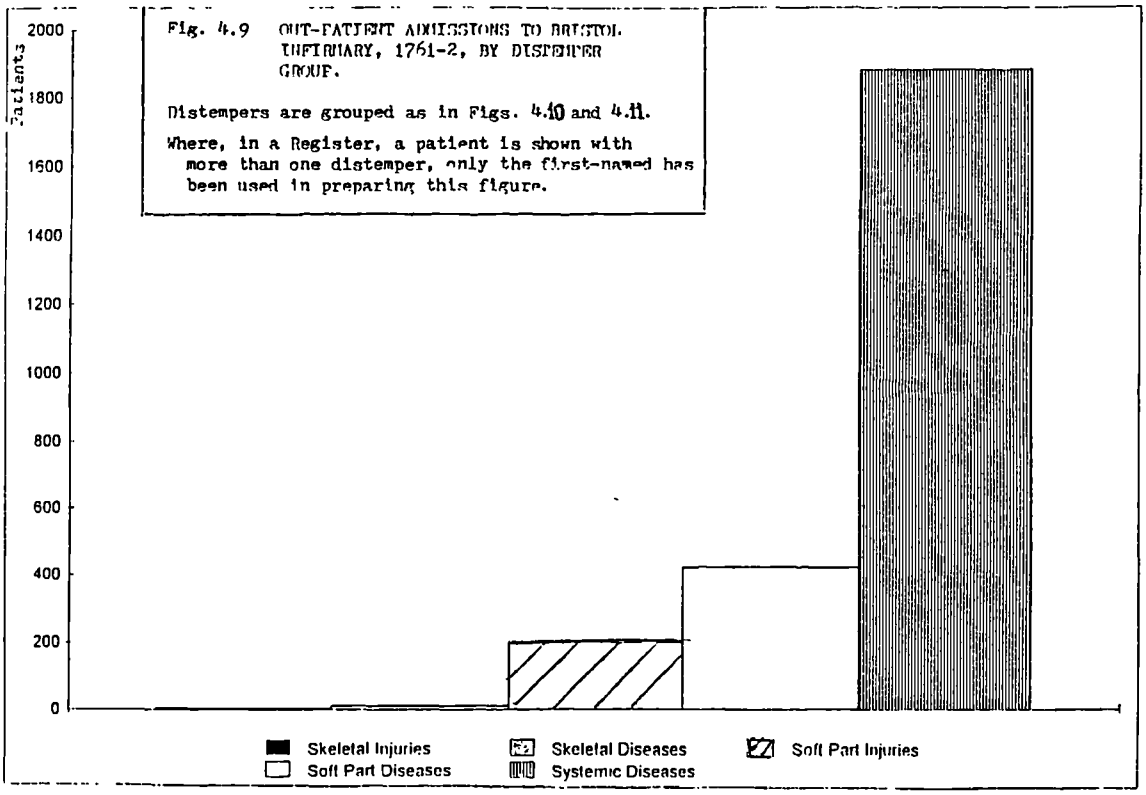


Fig. 4.9 OUT-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, BY DISTEMPER GROUP.

Distempers are grouped as in Figs. 4.10 and 4.11.

Where, in a Register, a patient is shown with more than one distemper, only the first-named has been used in preparing this figure.

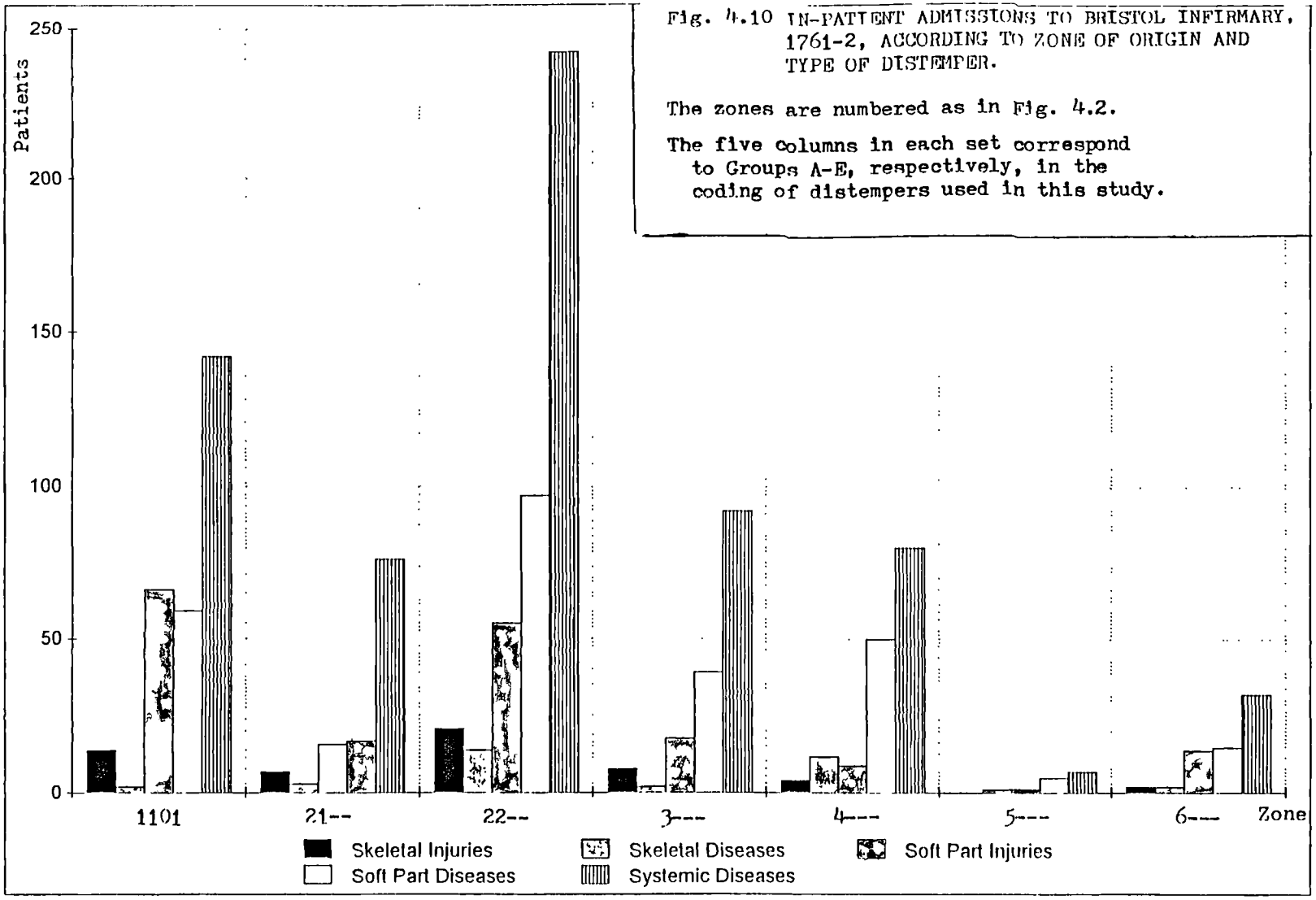


Fig. 4.10 IN-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, ACCORDING TO ZONE OF ORIGIN AND TYPE OF DISTEMPER.

The zones are numbered as in Fig. 4.2.

The five columns in each set correspond to Groups A-E, respectively, in the coding of distempers used in this study.

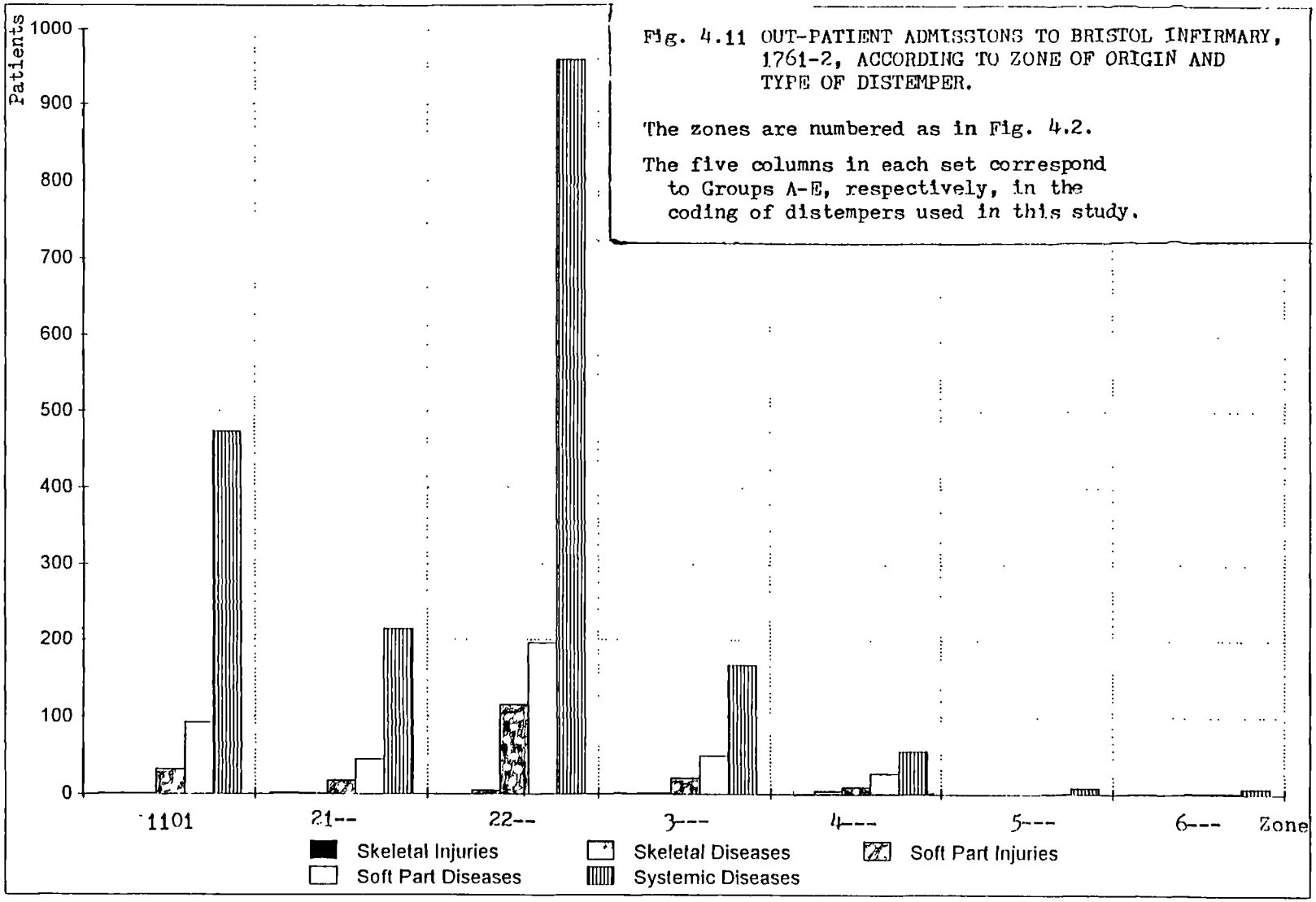


Fig. 4.11 OUT-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2, ACCORDING TO ZONE OF ORIGIN AND TYPE OF DISTEMPER.

The zones are numbered as in Fig. 4.2.

The five columns in each set correspond to Groups A-E, respectively, in the coding of distempers used in this study.

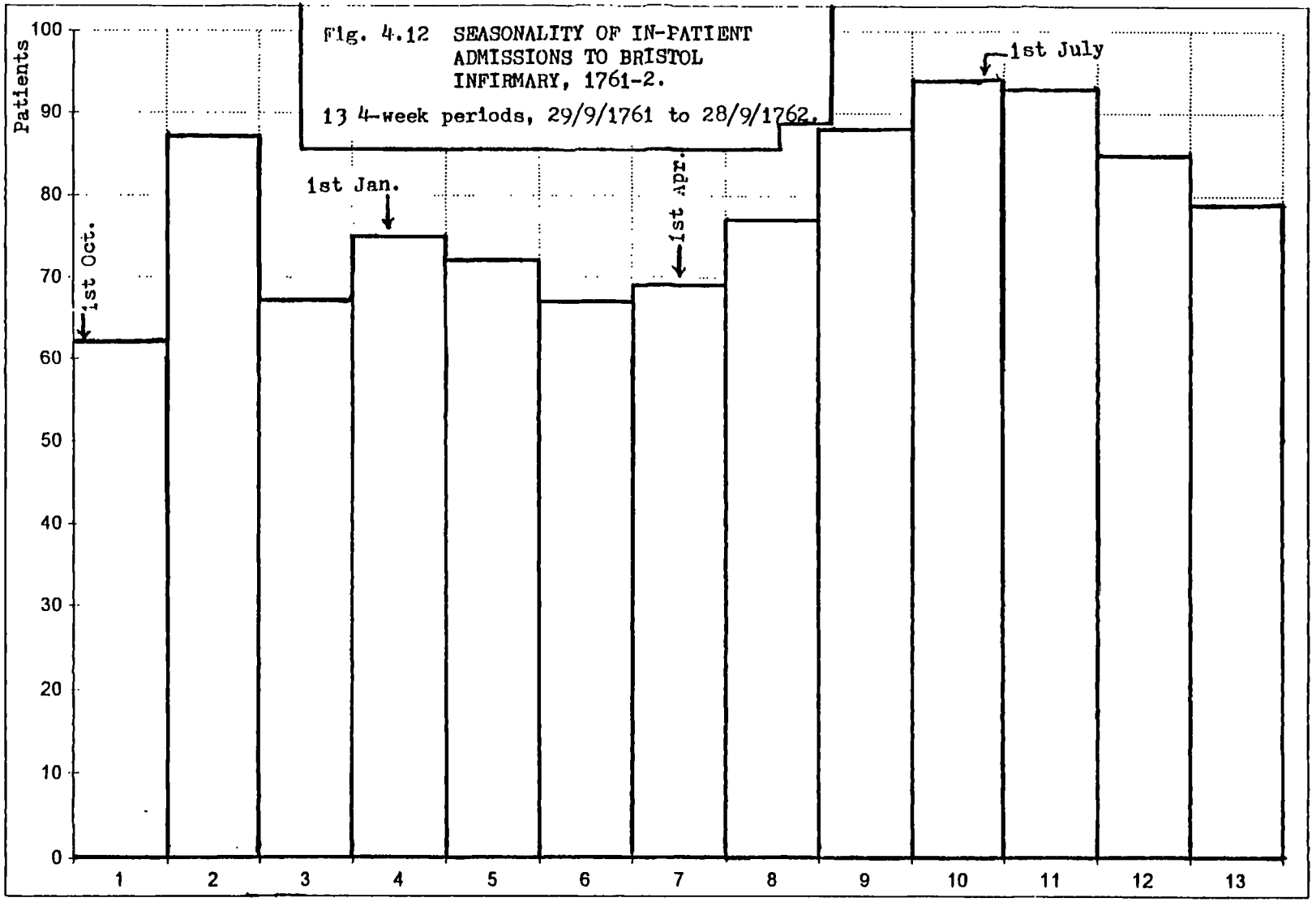


Fig. 4.12 SEASONALITY OF IN-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2.
13 4-week periods, 29/9/1761 to 28/9/1762.
Patients
100
90
80
70
60
50
40
30
20
10
0
1st Oct.
1st Jan.
1st Apr.
1st July
1
2
3
4
5
6
7
8
9
10
11
12
13

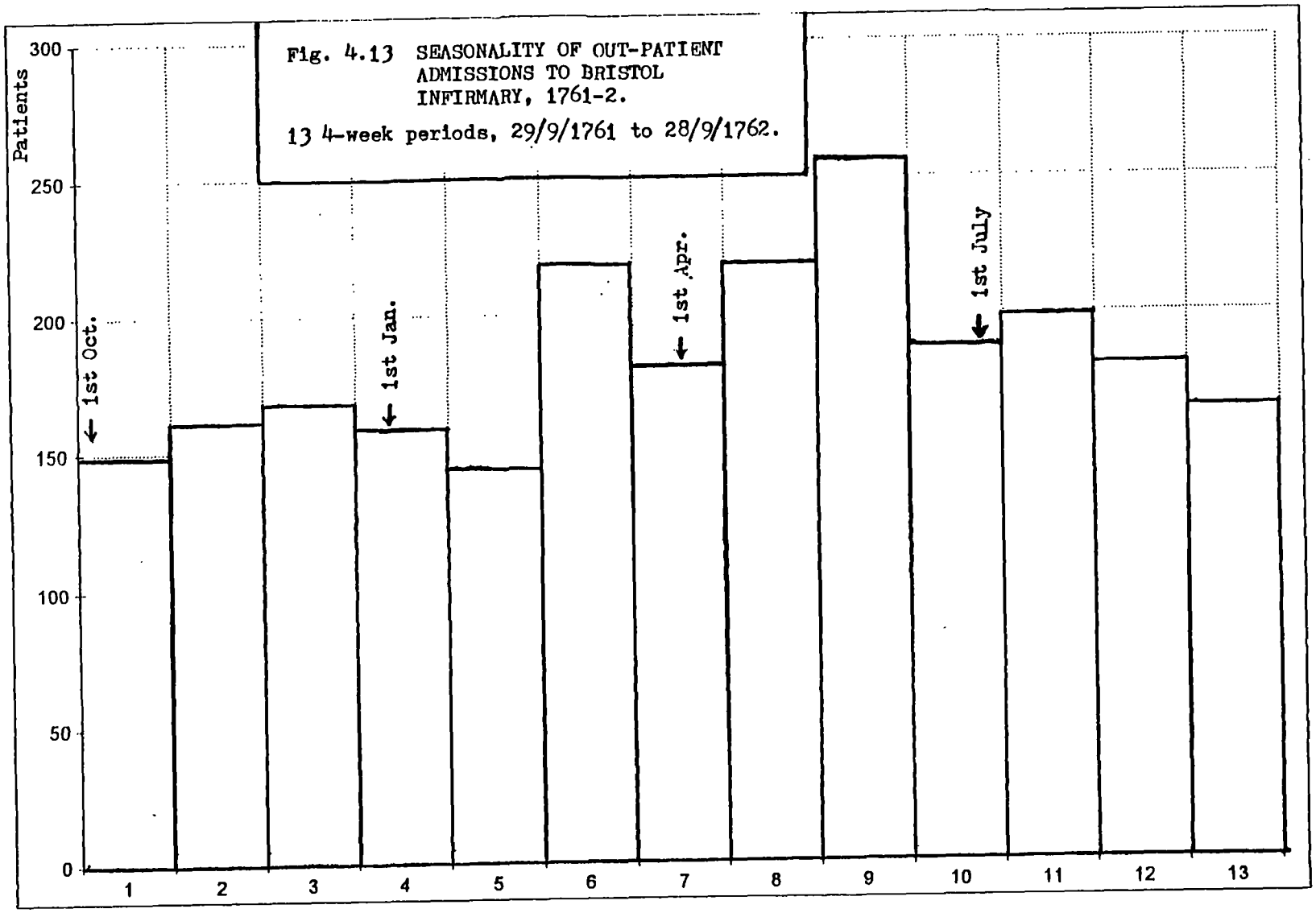


Fig. 4.13 SEASONALITY OF OUT-PATIENT ADMISSIONS TO BRISTOL INFIRMARY, 1761-2.

13 4-week periods, 29/9/1761 to 28/9/1762.

injuries is its high incidence of In-patient treatment, only 5 of the 58 patients presenting with fractures being treated as Out-patients. The sex ratio was 3:1 in favour of males.

One of the few Out-patients with a bony injury was a two-year-old female child with a fractured thigh.[17] It is true that the Infirmary had a Rule excluding the under-sevens but 2 other young children with fractures were admitted during this twelve month period. Perhaps her parents refused to allow her to be admitted to the wards or maybe the hospital decided that suitable home care was available. In any case young bones heal well and if this was a typical `greenstick' fracture of a young child where the bone is partly broken, partly bent, it would suffice to splint the limb and still allow mobility to the patient, for the bone ends would not get displaced.

In this study bony injuries affect all ages but occur mostly in males. A summer increase can be detected and a possible small peak in January/February. Certainly the majority of fractures occured in the April-September period and this is the time of year when most outdoor work is carried on: housebuilding, rigging of ships, etc. The small January/February rise may be due to inclement weather with ice making conditions difficult for pedestrians (see p.363). Bristol had already extended out into hills steeper than 1 in 10, for example, St. Michael's Hill.

The origins of patients with bony injuries are mainly local. As over 90% were admitted as Casualties and without a Subscriber recommendation, and as Casualty admission was an option open only to those who received their injury locally, this finding is not surprising.[18]

Although numbers of bony injuries are too small to justify statistical examination, the tendencies are worthy to be noted and remarked upon.

Bone diseases (Group B) The most startling point about these distempers is how few arise from the parish of St. James; only 3 cases out of a total of 44 (see p.363). This is not explicable with the material we have. The high incidence of bone disease in young adults (mostly `caries') can be seen, in modern terms, as probably due to tuberculosis (most likely bovine) and acute or sub-acute osteo-myelitis, the former probably being due to infection from milk and the latter probably more prevalent among the less well nourished. The age distribution is heavily weighted toward the 20 to 29-year-olds but the sex difference in numbers admitted is unremarkable. A small peak in admissions occurs in late autumn.

Soft part injuries (Group C) This group includes such conditions as dislocations, sprains, strains, contusions, excoriations, woundings, burns and scalds, and a meteorological accident. Specific distempers are too few in number to be open to generalization but as a group overall admissions rise and fall much in line with fractures and possibly arise from the same causes. The peak age is in the 30- to 40-year-old range, with 3 times as many men as women affected and this suggests occupational causes. It could also be that naval or military men injured in battle disembarked here from warships, the Seven Years' War still being in progress at this time.

Sprains, strains, and contusions (see p.364) are predominately the concern of Out-patient care, for these could often be precisely the sort of condition that left a patient remaining mobile and thus able to attend Out-patients. The value of Out-patient attendance was not lost on Reynell. As he commented in his Anniversary Sermon;[19]

> [Those] others whose Infirmities are not so pressing, as to call for their immediate Reception into the *Infirmary*, are relieved with Advice and Medicines as *Out-Patients*, and are enabled, by this Means, to continue on their Labours and Trades without Loss of Time, without being

burthensome to their Friends and Relations, or to the Parishes or Places to which they belong.

Castelman saw beyond the distemper and observed;[20]

A Family is often under such particular Circumstances of Distress, as necessitate the poor Sick to decline the greater Advantages peculiar to In-Patients, notwithstanding their Maladies render them but too proper Objects.

However, among those who were admitted to the wards as In-patients there is a predominance from the parish of St. James, while among Out-patients this holds for the outer city area.

As far as soft part injuries other than sprains, strains and contusions are concerned, the seasonal spread is largely similar to all other injuries. Also reflected is the high In-patient admission rate from St. James, as is the relatively large number of admissions from the group consisting of strangers, sailors. etc. (see p.365).

When the 58 patients with bone injuries are added to the 345 with soft part injuries it can be seen that a total of 403 people are affected, accounting for 11.8% of total admissions. A dip in numbers in early spring and a peak in summer comes out very sharply although numbers are maintained throughout the Winter.

The seasonality of employment could make it less attractive to recover at home by simply resting up at certain times of the year, while more exposure to dangerous work was increased by long days and good weather. Perhaps the peaks indicate more dangerous outdoor work in summer and more darkness and ice in winter, with spring and autumn less dangerous.

Diseases of soft parts (Group D) Distempers in this group are dominated by leg ulcers and with 210 cases during the twelve months this is clearly an important distemper[21] (see

Fig. 4.14 (i) SEASONALITY OF PATIENTS SUFFERING FROM LEG ULCERS AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

4-WEEK PERIODS		NUMBER OF ADMISSIONS	
NO.	DATES	IN-PATS.	OUT-PATS.
1	29/09/1761 - 26/10/1761	10	6
2	27/10/1761 - 23/11/1761	11	6
3	24/11/1761 - 21/12/1761	6	5
4	22/12/1761 - 18/01/1762	10	2
5	19/01/1762 - 15/02/1762	8	6
6	16/02/1762 - 15/03/1762	8	10
7	16/03/1762 - 12/04/1762	6	5
8	13/04/1762 - 10/05/1762	5	5
9	11/05/1762 - 07/06/1762	7	7
10	08/06/1762 - 05/07/1762	15	9
11	06/07/1762 - 02/08/1762	14	10
12	03/08/1762 - 30/08/1762	12	14
13	31/08/1762 - 28/09/1762	12	1
	TOTALS	124	86

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/9, p.367).

Fig. 4.14 (ii) ZONES OF ORIGIN OF PATIENTS SUFFERING FROM LEG ULCERS AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 -- 28/9/1762

ZONES OF ORIGIN		NUMBER OF ADMISSIONS	
ZONE CODING	AREA	IN-PATS.	OUT-PATS.
1101	St James parish	26	21
21--	City parishes (central*)	7	11
22--	City parishes (outer)	43	38
3---	Immediately outside City**	18	8
4---	Elsewhere in 6 neighbouring counties***	19	7
5---	Elsewhere	3	1
6---	`Strangers' etc., in City	8	0
	TOTALS	124	86

* I.e. not reaching City boundary
** Wholly or partly within 4 miles of Bristol Bridge
*** Somerset, Gloucestershire, Wiltshire, Herefordshire, Monmouthshire and Glamorganshire

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/9, p.367).

Fig. 4.14(i), p.166,) for seasonality and Fig. 4.14(ii), p.167, for area of origin). Nearly 60% of patients suffering from the condition were admitted to the wards, indicating that the medical staff did not always think it sufficient to dress the wound and send the patient away but rather that it was cure and not just palliative measures they were interested in. In most cases this is a condition, precipitated by poor local nourishment of the surrounding tissues, which responds best to bed rest with elevation of the affected part and professional bandaging, in the early stages at least, and probably only advanced cases would be warded. Nevertheless, the necessary care, especially in the early stages of treatment, makes it medically necessary to consider home circumstances when deciding whether to recommend In-patient or Out-patient treatment.

Fissell[22] makes the point that the length of time old people with ulcers spent in hospital was related to the availability of domestic care and from this finds support for the conclusion that the Infirmary provided a service as a place of residence, hence duplicating and supplementing Poor Law provision. Her conclusion begs the point. That admission or length of stay should be influenced by the availability of help at home has no necessary connection with a non-medical function of the Infirmary.

As the present study shows, among patients admitted to Bristol Infirmary in 1761-2 most ulcers were of the leg. Further, we can infer something of how leg ulcers were treated from the perennial principles from which came Baynton's new method.[23] Whatever the method used, the course of healing would have reached, in most patients, a point at which leaving the hospital would be therapeutically without adverse affect. If there was no assistance at home, this is likely to have been after no further surgical dressing was needed. With such assistance, going home could have been sooner, since the lesion could be dressed there, and departure from hospital would be possible once progress towards complete healing was assured. Also help at home

made possible the bed-rest, which may well have been considered important, as it may be now, for the healing of leg ulcers. Therefore the effect of home circumstances on the time of leaving hospital could have been due then, as today, to therapeutic judgment, and the evidence adduced by Fissell has no necessary implication that the Infirmary had the function of a Poor Law residence.

As distempers are grouped in this presentation, only leg ulcers and bony injuries occasion more In-patient than Out-patient admissions.

There is little to comment upon concerning ulcers which affected areas of the body other than the leg except to note that the proportion of In-patients to Out-patients is the reverse of patients with leg ulcers.

Neither is there much to comment upon in the group of distempers recorded as abscesses or localised infections, apart from noting that a surprisingly large number of patients from outside Bristol sought treatment as In-patients for these maladies. Conversely there was also a high incidence of city patients from the parish of St. James (see p.366).

Nearly all patients presenting with ophthalmia or related conditions were treated as Out-patients; almost all patients were local and probably the condition was not of such severity that sufferers would travel far to receive treatment (see p.365). The Bristol Pharmacopoeia contains a prescription for eye drops which could, no doubt, be self-administered at home. There is a rise of cases in late Spring which raises the question of the possibility that some, at least, of these cases could be pollen allergies. In this study, ophthalmia affects mainly the under-40's and twice as many females as male patients. Ophthalmia would correspond with today's `red eye` or `conjunctivitis' for the most part, still more common among younger than older age groups. As far as other eye conditions (see p.366) are

concerned there are too few cases to draw any serious conclusion but of the two patients admitted for treatment of cataracts one came from the inner city and 1 from the outer. While the patient from the outer city took his own discharge after a week, presumably untreated, the other remained in hospital for five weeks before being discharged as `Cured' following surgery.

Generalised diseases and diseases of the main systems of the body (Group E) This group of diseases is numerically the largest (accounted for mainly by the inclusion of `fevers' in the grouping). Nearly half of the In-patients and three-quarters of the Out-patients come in the category of Group E distempers, as defined in this work.

In the sub-group of fevers (EB), of which there were 357 cases, In-patient admissions show clear seasonality (see Fig. 4.15(i), p.171 for seasonality and Fig. 4.15(ii), p.172 for area of origin). This may be due to the fact that fevers severe enough to warrant In-patient care were just those with seasonal influence (see p.369). It is recognised, for instance, that the breeding habits of the anopheles mosquito, the vector responsible for malaria, are such that April to September sees a great upsurge in their numbers. As there was no standard nosological system in use at the time to which this study relates, the opportunity for inaccuracies in our understanding of the disease is potentially fairly high and, perhaps, nowhere more so than in the case of `fevers'. Fevers most likely to be malarial in origin include `ague', `intermittent fever', `tertian', `slow fever' and `anomalous intermittent'. This study shows a peak of all In-patient fevers in early summer and a small plateau around mid-Winter. When Out-patients are added in, the pattern is more smudged but still reveals a rise to, and a drop from, May and June. The age incidence for this distemper, as recorded in the Admission Registers, show that young adults, probably because of their earning power, were more likely to be In-patients than their more elderly fellow-citizens. The younger and stronger, with a

Fig. 4.15 (i) SEASONALITY OF PATIENTS SUFFERING FROM FEVERS AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

4-WEEK PERIODS		NUMBER OF ADMISSIONS	
NO.	DATES	IN-PATS.	OUT-PATS.
1	29/09/1761 - 26/10/1761	7	9
2	27/10/1761 - 23/11/1761	11	17
3	24/11/1761 - 21/12/1761	13	7
4	22/12/1761 - 18/01/1762	13	11
5	19/01/1762 - 15/02/1762	9	6
6	16/02/1762 - 15/03/1762	7	21
7	16/03/1762 - 12/04/1762	14	12
8	13/04/1762 - 10/05/1762	15	15
9	11/05/1762 - 07/06/1762	23	24
10	08/06/1762 - 05/07/1762	15	15
11	06/07/1762 - 02/08/1762	11	21
12	03/08/1762 - 30/08/1762	15	12
13	31/08/1762 - 28/09/1762	12	22
	TOTALS	165	192

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/12, p.369).

Fig. 4.15 (ii) ZONES OF ORIGIN OF PATIENTS SUFFERING FROM FEVERS AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

ZONES OF ORIGIN		NUMBER OF ADMISSIONS	
ZONE CODING	AREA	IN-PATS.	OUT-PATS.
1101	St James parish	38	53
21--	City parishes (central*)	19	21
22--	City parishes (outer)	66	89
3---	Immediately outside City**	19	22
4---	Elsewhere in 6 neighbouring counties***	15	6
5---	Elsewhere	1	0
6---	`Strangers' etc., in City	7	1
	TOTALS	165	192

* I.e. not reaching City boundary
** Wholly or partly within 4 miles of Bristol Bridge
*** Somerset, Gloucestershire, Wiltshire, Herefordshire, Monmouthshire and Glamorganshire

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/12, p.369).

consequently better prognosis, may have had some preference in a hospital as defined by its own Rules for the treatment of acute distempers with the prospect of cure. Writing of the period 1771-1805 and of the parish of Sts. Philip and Jacob, Fissell states that the elderly without kin were more ikely than the elderly with kin to be admitted as In-patients (as distinct from Out-patients) if they were suffering from, for example, fever,[24] again with the implication that the Infirmary was providing a service supplementary to the Poor Law. As with leg ulcers, however, the home care available affects decisions taken on medical grounds.

For the period under review `consumption' can be taken to mean any `wasting disease' and does not relate specifically to lung infection (see p.370). Anorexia nervosa for instance was styled a consumption (on this see Morton's *Phthisiologia*).[25] The numbers treated do not allow conclusions to be drawn, except that consumptions, other than phthisis, were largely Out-patient distempers although there was an unexpected burst seen among those attending Out-patients in April and May for phthisis itself.[26] As might be expected, young adults are especially affected, with little difference in numbers between the sexes.

Cough rises dramatically in May among Out-patients but, again, very few cases are warded (see p.371). This particular study reveals a very strong seasonal pattern (see Fig. 4.16(i), p.174, for seasonality and Fig. 4.16(ii), p.175, for area of origin). (Cough accounts for much of the overall rise in Out-patient attendances for the month and being dealt with on an Out-patient basis, there is no restriction upon its treatment by the shortage of beds.) The rise in this distemper is reflected in the rise of phthisis - is some `cough' a pre-consumptive symptom? Certainly an increase in cough occured around May 1762. Additionally, or alternatively, it may be that by early summer people sought help with winter coughs that had

Fig. 4.16 (i) SEASONALITY OF PATIENTS SUFFERING FROM COUGH AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

4-WEEK PERIODS		NUMBER OF ADMISSIONS	
NO.	DATES	IN-PATS.	OUT-PATS.
1	29/09/1761 - 26/10/1761	3	18
2	27/10/1761 - 23/11/1761	8	19
3	24/11/1761 - 21/12/1761	0	19
4	22/12/1761 - 18/01/1762	3	21
5	19/01/1762 - 15/02/1762	7	25
6	16/02/1762 - 15/03/1762	3	44
7	16/03/1762 - 12/04/1762	3	39
8	13/04/1762 - 10/05/1762	4	47
9	11/05/1762 - 07/06/1762	3	90
10	08/06/1762 - 05/07/1762	0	29
11	06/07/1762 - 02/08/1762	1	13
12	03/08/1762 - 30/08/1762	2	16
13	31/08/1762 - 28/09/1762	0	9
	TOTALS	37	389

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/15, p.371).

Fig. 4.16 (ii) ZONES OF ORIGIN OF PATIENTS SUFFERING FROM COUGH AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

ZONES OF ORIGIN		NUMBER OF ADMISSIONS	
ZONE CODING	AREA	IN-PATS.	OUT-PATS.
1101	St James parish	7	112
21--	City parishes (central*)	5	48
22--	City parishes (outer)	13	201
3---	Immediately outside City**	10	23
4---	Elsewhere in 6 neighbouring counties***	2	4
5---	Elsewhere	0	1
6---	`Strangers' etc., in City	0	0
	TOTALS	37	389

* I.e. not reaching City boundary
** Wholly or partly within 4 miles of Bristol Bridge
*** Somerset, Gloucestershire, Wiltshire, Herefordshire, Monmouthshire and Glamorganshire

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/15, p.371).

not terminated spontaneously in the spring, as coughs generally do. Again, a cough could be a sign of an underlying, more debiltating illness which might affect the chances of employment.

Asthma[27] appears constant throughout the colder months of the year but there is a rise in early summer. Could this early summer outbreak be associated with allergies also? The winter incidence could well result from chest infections and the winter months are necessarily the hardest months of the year, particularly for the `Laborious Poor' who may well not be `laborious' for much of the time. It is, however, a condition, like `cough', judged amenable to Out-patient treatment. The only In-patient recorded as suffering from asthma had it as a second distemper, after `cough' (see p.372).

Other respiratory diseases are largely, though not entirely, an Out-patient concern and show a slight seasonal movement upwards towards late spring and early summer flattening out as winter approaches (see p.372).

As discussed in Chapter 1, Bristol Infirmary was gaining a reputation for the operative treatment of urinary stone (see p.373). A total of 8 patients were admitted for this very painful and distressing condition with 6 of them being warded. (See Fig. 4.17(i), p.177, and Fig. 4.17(ii), p.178, for a numerical display of the seasonality and area of origin for the combined distempers of stone and gravel). However, in spite of the Infirmary's reputation only two were operated upon, of whom one was cured and the other died. Nevertheless, of the 6 In-patients, 5 undertook long journeys in order to seek treatment. It would be interesting to know more about this group. Were they of the `Laborious-Industrious Poor' class the Infirmary was set up to serve or were they monied people? How did they finance their trip? It should be remembered that stone is agony, and could easily override economic prudence and family obligations. As discussed in Chapter 3, Munro Smith tells us

Fig. 4.17 (i) SEASONALITY OF PATIENTS SUFFERING FROM STONE OR GRAVEL AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

4-WEEK PERIODS		NUMBER OF ADMISSIONS	
NO.	DATES	IN-PATS.	OUT-PATS.
1	29/09/1761 - 26/10/1761	0	1
2	27/10/1761 - 23/11/1761	0	3
3	24/11/1761 - 21/12/1761	0	1
4	22/12/1761 - 18/01/1762	2	2
5	19/01/1762 - 15/02/1762	1	2
6	16/02/1762 - 15/03/1762	2	5
7	16/03/1762 - 12/04/1762	0	5
8	13/04/1762 - 10/05/1762	0	5
9	11/05/1762 - 07/06/1762	1	5
10	08/06/1762 - 05/07/1762	2	7
11	06/07/1762 - 02/08/1762	0	1
12	03/08/1762 - 30/08/1762	1	6
13	31/08/1762 - 28/09/1762	1	0
	TOTALS	10	43

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/18, 8/19, p.373).

Fig. 4.17 (ii) ZONES OF ORIGIN OF PATIENTS SUFFERING FROM STONE OR GRAVEL AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

ZONES OF ORIGIN		NUMBER OF ADMISSIONS	
ZONE CODING	AREA	IN-PATS.	OUT-PATS.
1101	St James parish	3	14
21--	City parishes (central*)	0	3
22--	City parishes (outer)	1	24
3---	Immediately outside City**	0	2
4---	Elsewhere in 6 neighbouring counties***	6	0
5---	Elsewhere	0	0
6---	`Strangers' etc., in City	0	0
	TOTALS	10	43

* I.e. not reaching City boundary
** Wholly or partly within 4 miles of Bristol Bridge
*** Somerset, Gloucestershire, Wiltshire, Herefordshire, Monmouthshire and Glamorganshire

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/18, 8/19, p.373).

that these patients were allowed to engage their own nurses if they could afford to do so, otherwise they came under the care of a woman who, by experience, had learnt the management of such cases. (The improbability of patients being able to pay for this service has also been raised in Chapter 3.) For other male urinary and genital disorders (other than venereal disease) see p.374.

There was no successful non-surgical treatment for this ailment, although medicines alleged to dissolve calculi were in use in the 18th century and on sale locally.[28] Out of the 8 patients only 1 was `cured', 6 were `relieved', (presumably not fully healed) and 1, a ten-year-old boy died following surgery. However, 40 Out-patients were teated for `gravel' (the precursor of urinary stones (calculi), since the minute stones can be nuclei around which bigger stones form). Out-patient treatment appeared to suffice for most of these cases and all but 3 were deemed to have been `cured'. While most sufferers from `gravel' were local inhabitants, even in the very small number of In-patients involved, just 4, 1 came from outside the city.

Parasitical intestinal worms were a common affliction and may have affected a large proportion of the population. Mainly the distemper was treated in the Out-patients but, surprisingly, 7 patients were warded. The geographical distribution is local and about two-thirds of all patients with worms were under ten years of age. This is not surprising; roundworms particularly are commonest in children and infection requires no animal as an intermediate host (see p.374). The seasonality and origins of other gastro-intestinal conditions are charted on p.375.

Diarrhoea and dysentery peak in high summer and are probably fly-borne infections (see p.375). The number seeking treatment at the Infirmary probably understates its prevalence, as it does at this day, since only those suffering the more severe symptoms would seek professional treatment, home remedies being easily available and often

effective. As these conditions are often associated with poor housing, poor sanitary arrangements and lack of a clean water supply it might be argued that Walpole's view of the city was more accurate when he wrote about his visit in 1766, than was Defoe's impression (see Chapter 1, pp.30-1). However, Bristol had a long-standing soap-making industry (soap was an issue between Bristol and the first Stuart king,[29]) and standards of hygiene in the home may perhaps not have been at rock bottom for many of the moderately poor. On the other hand, where diarrhoea is usual, many do not bother. The number of patients giving an address outside the city is surprisingly high. Were these patients visitors to the city who had no immunity to local bacteria?

With respect to the distempers in this group, it is to be remembered that, in the period under discussion, the terms cholera, typhoid or typhus were not used with their modern meaning. None of these words appear in the Register. Cholera, in the modern sense, had not yet come to Britain (although the name was already in medical use) and dysentery was not seen as a distinct entity from typhoid. While, as already stated, no case of typhus appears by that name in the Registers for the time under review the terms slow nervous fever, nervous fever and putrid fever do appear and indicate mild typhus in the first two instances and typhus in the third (see p.375).

The number of Out-patients coming from the outer city parishes with menstrual or female genital disorders is relatively high (see p.376). This may reflect employment patterns, with women in domestic service in the outer parishes having access to Subscriber recommendations relatively easily and possibly finding a fellow-feeling among their female employers. (These distempers are largely `Fluor Albus' or the `whites', that is leucorrhoea[30]) Apart from the more serious manifestations of disease of the female genital or reproductive system most patients were treated as Out-patients and most were discharged as `cured'.

Fig. 4.18 (i) SEASONALITY OF PATIENTS SUFFERING FROM VENEREAL DISEASE AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

4-WEEK PERIODS		NUMBER OF ADMISSIONS	
NO.	DATES	IN-PATS.	OUT-PATS.
1	29/09/1761 - 26/10/1761	3	2
2	27/10/1761 - 23/11/1761	4	3
3	24/11/1761 - 21/12/1761	1	3
4	22/12/1761 - 18/01/1762	3	3
5	19/01/1762 - 15/02/1762	4	2
6	16/02/1762 - 15/03/1762	3	1
7	16/03/1762 - 12/04/1762	2	0
8	13/04/1762 - 10/05/1762	3	4
9	11/05/1762 - 07/06/1762	4	2
10	08/06/1762 - 05/07/1762	2	2
11	06/07/1762 - 02/08/1762	7	4
12	03/08/1762 - 30/08/1762	2	2
13	31/08/1762 - 28/09/1762	2	2
	TOTALS	40	30

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/26, p.377).

Fig. 4.18 (ii) ZONES OF ORIGIN OF PATIENTS SUFFERING FROM VENEREAL DISEASE AND ADMITTED TO BRISTOL INFIRMARY, 29/9/1761 - 28/9/1762

ZONES OF ORIGIN		NUMBER OF ADMISSIONS	
ZONE CODING	AREA	IN-PATS.	OUT-PATS.
1101	St James parish	8	10
21--	City parishes (central*)	0	3
22--	City parishes (outer)	11	14
3---	Immediately outside City**	6	2
4---	Elsewhere in 6 neighbouring counties***	4	0
5---	Elsewhere	1	1
6---	`Strangers' etc., in City	10	0
	TOTALS	40	30

* I.e. not reaching City boundary
** Wholly or partly within 4 miles of Bristol Bridge
*** Somerset, Gloucestershire, Wiltshire, Herefordshire, Monmouthshire and Glamorganshire

These data are incorporated into the more comprehensive graphic display in Appendix 8 (App.8/26, p.377).

Quite a number of these Out-patients though failed to keep their appointments and were discharged for `non-attendance'.

Patients with venereal diseases (see p.377) were explicitly excluded from the Bristol Infirmary yet 40 patients were warded and 30 others treated as Out-patients for its manifestation (see Fig. 4.18(i), p.181 for seasonality and Fig. 4.18(ii), p.182 for area of origin). The Rule Book, version of 1779, allows for `extraordinary or particular Cases' to be admitted[31] and this Rule may have been an official validation of what was already happening in practice. It could be assumed that one such special case was Grace Baily, an eight-year-old admitted from Temple with the diagnosis of gonorrhoea.[32] She was discharged as `Cured' after 6 weeks of hospitalisation. We do not know if this was a case of persistent gonorrhoea from an intra-partum infection or not. The use of the word `gonorrhoea' may have been less precise than now. From the parish of St. James came 18 of the patients with venereal disease, 8 of whom were warded, as were all 10 who presented with this infection from amongst the foreigners, soldiers, sailors and strangers. Bristol was a port! (On seafaring attitudes to venereal disease, one may consider the song `Cruising round Yarmouth'.[33])

Many of Bristol's `Laborious-Industrious Poor' must have suffered from the disabling condition of rheumatism or other localised musculo-skeletal disorders (see pp.377-8). (Rheumatic fever was recorded as such, and affected only 2 patients in the study.) Such distempers might or might not reflect inadequate, damp housing conditions or exposure to unfavourable weather elements. A number of such sufferers found their way to the hospital and about one-third of the almost 200 applying for help were warded. A surprising finding is the number of Out-patients with addresses outside the city. Obviously this was a condition which was perceived as needing professional help and advice. A slight hump can be made out for early spring with a drop immediately following but numbers are generally

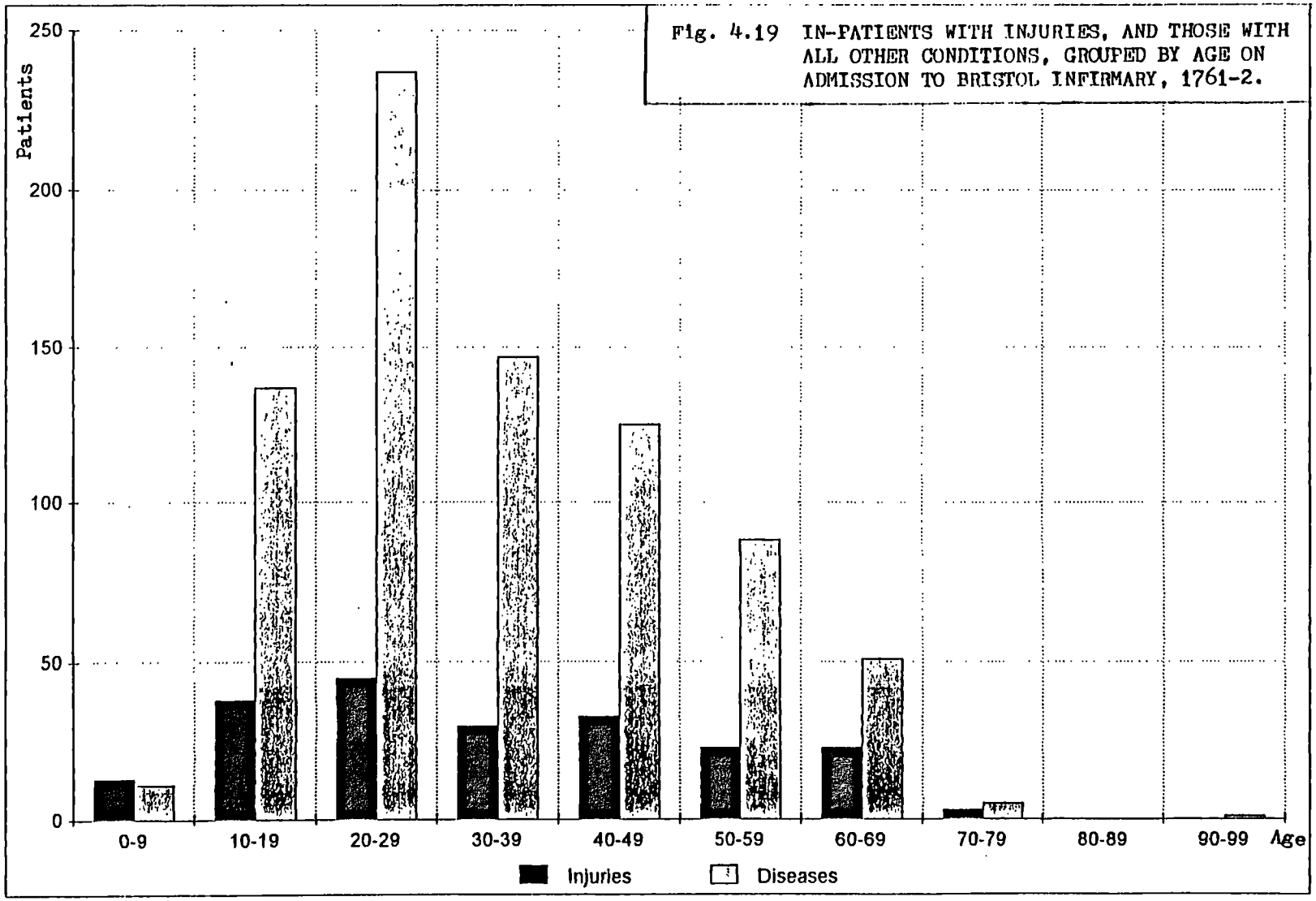
maintained throughout the year. The adult age distribution is not markedly different from that for all patients combined. There is only a single mention of gout. Presumably patients with this condition, traditionally of the port-drinking gentry, could afford to consult their own physician!

There is no clear evidence from the Infirmary records that scurvy or scorbutic distempers appeared among the local population in spring, the end of a period without locally-produced fresh vegetables. Bristol was a port and a city with a money-based economy and it may have been the case that Spanish oranges and other imports of fresh food were available. While the rural communities were governed by the overall exigencies of the growing year, not so cities with imports. Infirmary diet has been presented in Chapter 3 and Appendix 7 but Porter points out that the diet of the labourer consisted mainly of bread and cheese with the addition of a little fat bacon and that adulterated tea tended to replace milk and beer, although the spread of potatoes did improve nutrition with the passing of time.[34]

The period under discussion here was before the introduction of limes into the Navy diet in 1795 but even as late as 1910 ideas on scurvy were confused, although clear by 1922, as judged by a comparison of the 11th and 12th editions of the Encyclopaedia Britannica. The adjective `scurvy' referred to a scabby skin, and not all patients with `scurvy' need have had the disease characterised by weakness, swollen joints and bleeding gums, and now attributed to deficiency of ascorbic acid (vitamin C). As the numbers keep up throughout the year the term may have been used quite widely.

Like the other 4 groups, - bone injuries, bone diseases, soft part injuries and diseases of soft parts, - not all distempers in this group of generalised diseases and diseases of the main systems of the body are able to be considered specifically. A `rag-bag' remains but

Fig. 4.19 IN-PATIENTS WITH INJURIES, AND THOSE WITH ALL OTHER CONDITIONS, GROUPED BY AGE ON ADMISSION TO BRISTOL INFIRMARY, 1761-2.



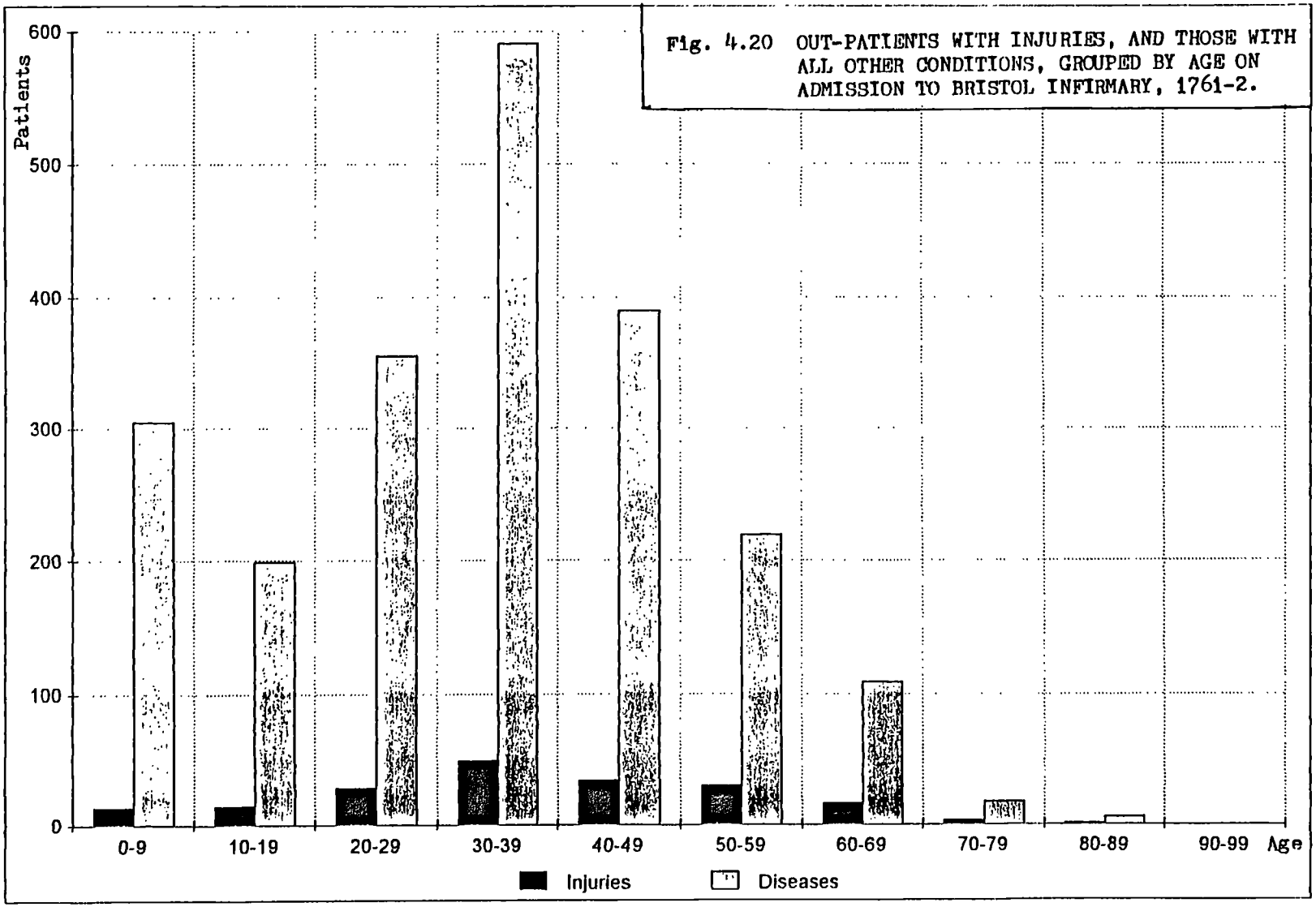
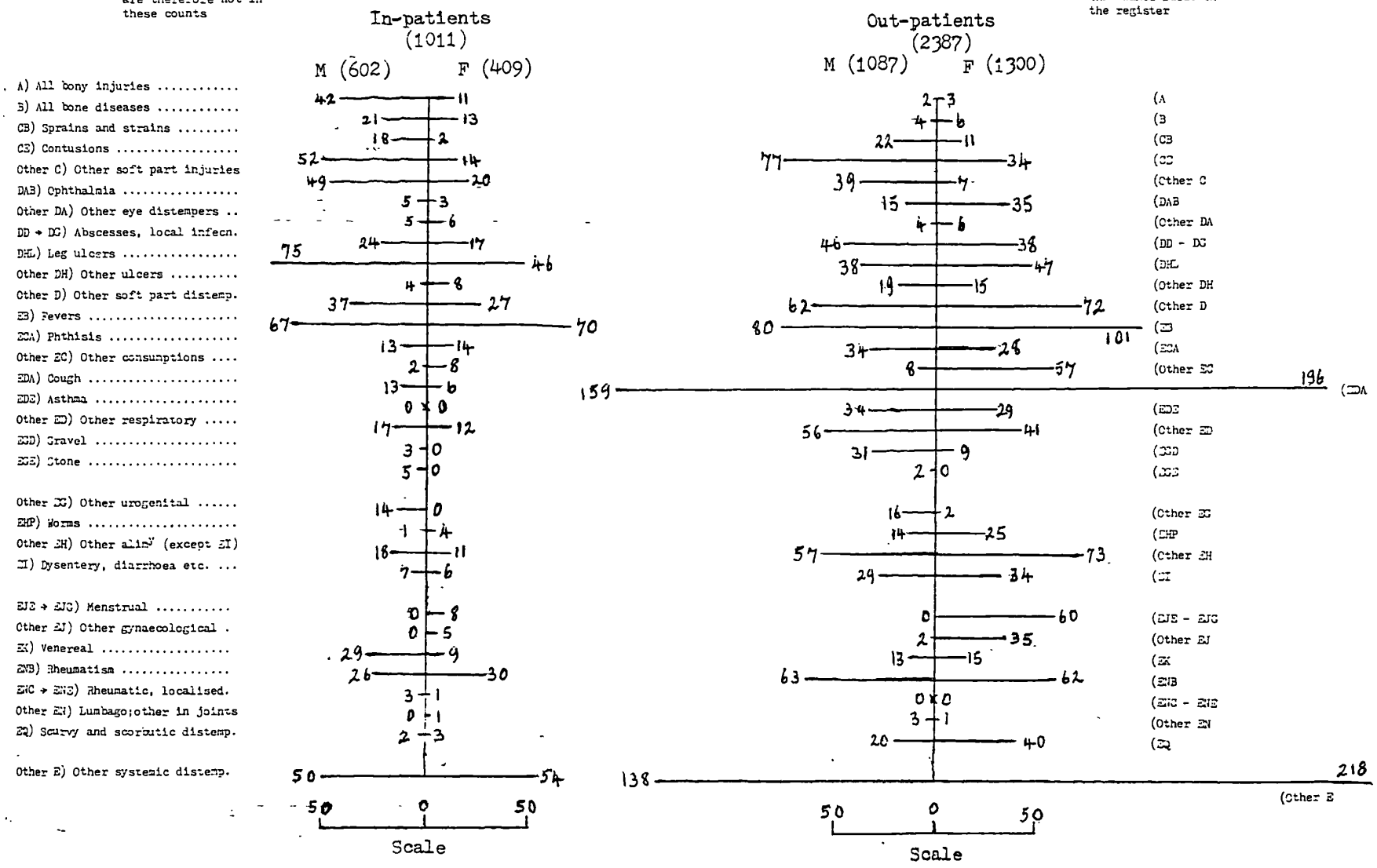


Fig. 4.20 OUT-PATIENTS WITH INJURIES, AND THOSE WITH ALL OTHER CONDITIONS, GROUPED BY AGE ON ADMISSION TO BRISTOL INFIRMARY, 1761-2.

Fig. 4.21 Bristol Infirmary (1761-1762);
SEX DISTRIBUTION OF PATIENTS BY DISTEMPER

The register lacks distempers for four male in-patients, who are therefore not in these counts

Patients with more than one distemper are allocated to that named first in the register



this `rag-bag', consisting as it does, of various nervous, mental and oral conditions, dropsies, skin disorders, liver and bile disorders, haemorrhagic and fainting conditions, diabetes and tetanus serves well to illustrate the variety of conditions dealt with at the Bristol Infirmary and which may have reinforced the influence the Infirmary wielded both locally and further afield (see p.380).

The distribution of patients' ages, with specific respect to injuries and to diseases, are illustrated in Figs. 4.19 (p.185) and 4.20 (p.186), and by sex and first-named sub-distemper group in Fig. 4.21 (p.187). (See Fig. 4.1, p.143, for admission, by sex of patient, regardless of distemper group.) As can be seen by reference to Fig. 4.19 (p.185) the admission of young children as In-patients is very restricted by the Rule excluding children. No such restriction occurs amongst Out-patients either by Rule or in fact. At the other end of the age range the proportion of In- to Out-patients is much the same as of the patients as a whole. We do not know to what degree age-distribution of admissions reflects that of the incidence of distempers in the population generally nor to what degree other factors, such as age-preference by nominating Subscribers, might bias the numbers. The hospital was designated for the admission of the acutely ill among the `Laborious-Industrious Poor' and the illnesses of aged people are often of the chronic order while the sufferers themselves are beyond the industrious, laborious time of life. As can also be seen from the Figures, male patients outnumbered females as In-patients, a ratio of almost 6:4 but the sitation was reversed in the Out-patients where it was 46:54.

4.5 CONCLUSIONS

The overall picture of attendance at Bristol Infirmary for these twelve months is not quite what one would expect from Webster's comments.[35]

> Admissions were dominated by abscesses, tumours, ulcers, burns, and a variety of skin complaints. The only indicators of changing social conditions were occasional admissions for burns or fractures occasioned by industrial accidents.

In this present study `abscesses, tumours, ulcers, burns, and a variety of skin complaints' accounted for only 25% of admissions but it is also true that ulcers of the leg accounted for more admissions in the twelve months than any other single condition.

More generally, the observations in this chapter show that admissions to the Infirmary reveal no conspicuous deviation (due either to selection or exclusion) from what would be expected in a hospital that was acute and designed for the `Laborious-Industrious Poor'. It is true that a number of the distempers might be thought by the modern reader to be chronic, for example, phthisis, leg ulcers or asthma. However, where treatment relieves or temporarily cures a condition, the condition may have been considered acute, relapses being regarded as new occurrences. Most patients had conditions which would still be considered acute, but the word `acute' is used here according to modern usage and occurs rarely in the sources, used in this work, from the 18th century, when the word had a rather more restricted use than now.

One kind of pauper, those poor because of chronic sickness, would have been excluded from In-patient admission by the need for an expectation of cure within three months. More positively, it is surely in keeping with admission of the `Laborious-Industrious Poor' that 20.5% of admissions to the wards were due to injury, and of In- and Out-patients taken together, 11.8%. Of all injuries, 74.7% were suffered by men, and the vast majority of specified injuries were compatible with workplace accidents, although it is probable that many were not due to the patient's occupation. More meaning may, however, be attached to the rise in injuries when the days were long, in summer.

A patient, having gained admission, was not going into some unheard of institution, but into a hospital playing a major part in the life of Bristol. In-patients admitted from city parishes in the twelve months under investigation amounted to almost 2% of the population, and the total of In- and Out-patients together to 7.4%. (Nevertheless, 26.5% of In-patients, and 13.6% of Out-patients came from outside the city, with no backing from the poor law funds of their own parishes at this time.) A feeling of the Infirmary's civic importance would, however, inspire confidence in the patient only if it was known to be therapeutically successful. Whether it was successful is the subject of work to be reported in the next chapter.

CHAPTER 5

Treatment : risk and healing

5.1 INTRODUCTION

The consideration of treatment which now follows also bears upon attitudes to patients. Given the cost of dressings and drugs, and it can be assumed that these would form the major part of the items listed in the extract of accounts in the annual Hospital States as `Medicines and other Materials for the Use of the Apothecary and Surgeons', the temptation to cut corners and economise could often have been present. Nevertheless, financial considerations are not the whole story. Care and attention are needed in the application of treatment, in, for example, the dressing and bandaging of very painful leg ulcers, if the patient's comfort is to matter, and in the care given, and sometimes time spent, in arriving at a correct diagnosis if the appropriate therapy is to be given. In this study no evidence has come to light of neglect or careless treatment within the Infirmary or that going through the motions mattered more than the patients. Beyond this negative generalisation, and more positively, therapy can be taken as one of the indicators of the attitude of the providers towards those provided for.

This can be illustrated by two extreme examples from the 20th century. The National Health Service started out as, and for about twenty years remained, governed by the demands of the sick (leaving of course more to be done for those unskilled in demanding). On the other hand, it was officially recommended in the 1960's that aspirins and `Vaseline' should be kept in reserve against the possibility of a nuclear attack.[1] Thus actions indicate underlying attitudes. Correspondingly, we can ask whether in 1761 and 1762 patients of the Bristol Infirmary benefitted from the state of the art or whether they were fobbed off with the remedies of inertia and convention.

The first matter to be noted in this chapter is the 18th century perception of the healing arts, in Bristol at least, as dependable for the restoration of health. Attention will then given to some modern opinions on whether and in what way 18th century patients benefitted from admission to a voluntary hospital. This leads to an analysis of data relevant to causes of death and intercurrent disease among patients in Bristol Infirmary and, after note is taken of some items of information from Richard Smith's *Biographical Memoirs*, features of the Bristol Infirmary Pharmacopoeia (1777) are discussed.[2] (The publication date does not make the Pharmacopoeia irrelevant to 1762, as it is not in itself an occasion of therapeutic innovation.) It can be seen that the medicinal formulae themselves provide indications of attitudes to patients. Next, given the treatment available according to the Pharmacopoeia, and having regard to what is otherwise known of the practice of the time and its outcomes, this chapter presents an assessment of therapeutic efficiency in certain conditions featured among distempers noted in the Admission Registers. Finally, some general conclusions will be drawn and it will be shown that treatment in the mid-18th century Bristol Infirmary was as good as the best practice of the time made possible, and that this practice was, for a large proportion of patients, conducive to recovery or alleviation.

5.2 CONTEMPORARY PERCEPTION OF THERAPEUTIC EFFICACY AT BRISTOL INFIRMARY, 1761-2

In order to understand the motives generating and sustaining the Bristol Infirmary in its early years, it is necessary to assess what may have been the hospital's expected effects. Was the Infirmary perceived to be effective in bringing about or furthering recovery from disease and injury, or was the building there merely to provide shelter for the incapacitated, as Fissell would have us believe?[3] We know that before the founding of the Infirmary there was already faith in the efficacy of the local physicians' attention.

In 1700 John Cary reported to Parliament on the working of the 1696 Act which instituted the Bristol Corporation for the Poor, noting the improvement in health occasioned by the care of the physicians for the sick poor of the city (see Chapter 1).

When in 1711, and still before the Infirmary's founding, a supporter of the old parochial system of relief held the Corporation's medical and surgical service to be weak in its effects, the weakness was seen to be due to the lack of experienced healers, not to the healing arts.[4]

> But to the Point. If we survive this Corporation, and continue in our right Minds, we shall think at least as much Care of this Kind, to be needful, as is taken now, and, I hope, somewhat more; I am sure more is very Necessary. As to Expence of Physick, no Boundaries are set to that, by a certain salary. Then why might it not be possible to meet with some other Men in the Town, not much inferior in Knowledge and Integrity, to the Person that now engrosses the Whole, who would look after any particular Parish on as easy Terms, as 'tis now done? But suppose the Expence in most Cases was far greater; so as the Case was answerable, would it not be Mony sav'd on the General, When Humanly speaking, A sick Person might sometimes be brought about in a few Days, that, now, lyes Languishing for Months, or Years.
> The Surgeons indeed have a certain Salary, viz 32 L. per Annum.But how well this answers, might be wofully seen by any Person, that would give himself the Trouble, of examining into Particulars. Very rarely any Cure is made, for it's usually left to the Management of Raw Servants, by which they are to gain Experience; an expensive Way to some of those Poor Creatures! But indeed if the Young Men really improve Themselves thereby, it may be said, That the Rich are Cur'd at the Expence of the Poor. But if this Way is approv'd of cannot every particular Parish have its Surgeon at a certain Salary? Surely I believe without Difficulty.

Thus, for this writer, although he contradicts Cary, the failure of medicine and surgery implies the need not to doubt their benefits, but to strengthen their practice.

Once the Infirmary had become the scene for the healing art, the effectiveness of the latter was held to be enhanced by its internal environment. Thus we read in Thomas Broughton's Anniversary Sermon of 1752 this claim;[5]

> Nor is Relief the only Advantage the Sick Poor derive from this friendly Interposition in their Favour. *Relief* may be afforded them under their own humble Roofs; but not in the *Manner* they experience it in an *Hospital*: where the Comforts of a warm and commodious Lodging, wholesome and palatable Food, careful and diligent Attendance, All unite to assist Nature in receiving the Benefits of Medicine, and to procure an expeditious and effectual Cure.

When, however, we answer `yes' to the question whether the Infirmary was perceived as therapeutically effectual, we are immediately confronted with a second question, whether the perception was justified by events. Did the Infirmary in fact assist in changing the course of sickness towards health, or was it ineffectual or even positively harmful?

A question about the effectiveness of therapy can be hard enough to answer when the patients are our contemporaries, and when detailed notes of symptoms, signs, treatment and outcome are still to hand. It is little to be wondered at that to-day's historians disagree about the therapeutic benefit, if any, of Infirmary treatment in these early years, and a long established tradition of pessimism exists among historians of the `British Voluntary Hospital Movement'. In 1926 M.C.Buer was writing that[6]

> Until the medical reforms of the latter half of the 18th century the sick were probably infinitely better off in their homes than they would have been in an institution.

Nearly thirty years later McKeown and Brown wrote of hospital care of the 18th century,[7]

> Indeed, the chief indictment of hospital work at this period is not that it did no good, but that it positively did harm.

Webster is kinder, though still grudging. He writes,[8]

> Usually by facilitating convalesence, sometimes by efficient minor surgery, occasionally by well-attested medical treatment, each hospital brought genuine relief to a modest number of In-patients.

These generalisations do not, however, always stand up to more detailed examination of the evidence. Thus in 1966, Sigsworth, (as quoted by S.Cherry), was led by his study of York County Hospital to remark that the reputation of 18th century hospitals[9]

> stands in a more favourable light when attention is focused upon the actual records of the hospitals themselves and on the patients which they treated.

Cherry's detailed study of the Norfolk and Norwich Hospital leads also to conclusions less pessimistic than those of McKeown and Brown, but the later date of this hospital, founded in 1771, makes comparison with the Bristol Infirmary hazardous particularly since, as can be deduced from Cherry's work, rates of cure and mortality change from decade to decade.[10]

Woodward's more general study is of interest because he brings to bear upon crude categories such as `Cured' and `Died' detailed consideration of specific maladies and injuries, together with their treatment and outcome. He concludes that, during the 18th and 19th centuries[11]

> the hospitals did achieve what appears to be a remarkable degree of success in treating their patients and the mortality remained at a low level throughout the period, generally being under 10 per cent of the patients admitted.

This present work leads, as will be shown, to a conclusion compatible with Woodward's.

However, we may be able to give a more exact value to Webster's term `modest', and be led to appreciate a little of what became of those to whom `genuine relief' was not afforded. To this end we shall be concerned with three sets of data: the patient's distemper, the duration of In-patient stay, and the outcome of that stay, be it death, cure, or some other. By interpreting the discharge state of all patients admitted during the discrete period of the twelve months under study, in the light of the distemper and duration of stay, we shall be able to use numbers to seek conclusions about the effectiveness and dangers of treatment in relation to specific risks and distempers. While the nature, duration and outcome of illness were also of concern to Woodward, he, in general, took them as separate topics while here we are keeping them together for the assessment of risk, harm or benefit to patients, according to their condition. Fortunately the treatment of many of our patients is known, some because stated in the Register, but many because it is inferable, with reasonable confidence, from the customary practice of the period or the Pharmacopoeia.

5.3 DEATHS IN THE BRISTOL INFIRMARY, 1761-2

The 86 patients who died constituted 8.5% of In-patients. This proportion was normal for the times, as a reading of Woodward[12] will show, but the usefulness of such a percentage is doubtful, even if in common use among historians. The death-rate in a hospital can be affected by the kinds and severity of distempers admitted and by the ages of patients, both of which may depend on either written Rules or on the unwritten customs governing their interpretation. The writer lives in a town the hospital of which has two wards, one medical and predominately concerned with the chronic and often lethal ailments of the old, the other surgical and almost exclusively used by patients, mostly young, needing uncomplicated and inextensive surgery. That the former ward has an appreciable death-rate and the latter virtually no deaths is not surprising, and the difference is hardly attributable to a difference in the

quality of care. This snippet of information is offered here as a reminder that, on principle, the death-rate in a hospital, when taken alone, can seldom be an indicator of the quality of service. More can be learnt when notice is taken of the particular circumstances of particular patients who died. (Patients will often be referred to in this discussion by their unique four digit Index Number alone. See Appendix 1, pp.280-1 for fuller information on this coding.)

There were 4 patients who died after surgical operation.[13] In the first of these infection or the handling of the bowel in reducing the `epipocele' (epiplocele, a hernia containing omentum[14]) could have caused a recrudesence of the `old passio iliaca' (painful inflammation of the small intestine) associated with it. Next, death within one day of repairing a hernia, as a `bubonocele' would now be called, must surely be due to the treatment, and the death of a boy after cutting for a stone in the urinary bladder almost certainly was. This was the only death among 8 patients cut for the stone. In the patient who died after the amputation of a leg with a carious bone, it is not known at what time during her ten-month stay in hospital the amputation was performed.[15] If the operation was early in this period, death could well be due to the long-term complications of surgery but it is also possible that the patient died from the toxicity of the caries, together with the shock brought about by an operation too long postponed in the hope of recovery without amputation.

An inexplicable death is that of a patient with an ulcerated leg.[16] The dressings, bandages and bed rest could hardly have endangered life. There could have been haemorrhage from a varicose vein (or even from an eroded nearby artery?), although in hospital this would almost certainly have been staunched before a fatal outcome. Death from unrelated causes still affects hospital patients today.

Fig. 5.1 INCUBATION PERIODS AND DURATION (EXCLUDING INCUBATION PERIODS) OF SPECIFIED INFECTIONS. (These data are used in Chapter 5, in assessing whether intercurrent infection took place before or after admission.)

TETANUS

1) Incubation: Usually 8 - 12 days, up to 100 days. known, less than 5 days rare, never less than 2 days.
2) Symptoms: Up to 3 weeks.

SMALLPOX

1) Incubation: 9 - 15 days, usually 12 but 5 - 20 or more possible.
2) Symptoms and infectivity: up to 4 weeks.
3) Death: most usual in 2nd week or during convalescence.

MEASLES

1) Incubation: 3 weeks.
2) Symptoms: for not more than 10 days.
3) Death: due to pulmonary complication and may therefore be later than expected recovery date. (But see entry 0259M in Figure 5.2).

PUTRID FEVER (i.e. TYPHUS)

1) Incubation: 12 days common, 5 - 14days, even 21 days possible.
2) Symptoms: 3 weeks.
3) Death: most usually in 2nd or 3rd week.

(After Tidy)

Source - Sir Henry Tidy, *A Synopsis of Medicine*, 10th edn., Bristol, John Wright, 1954.

Ten patients died after being `seized with' infections manifested after admission (included in Fig. 5.3, p.207). Using the information given in Fig. 5.1, p.198 and assuming that death occurred when the intercurrent distemper was still present, the following conclusions can be drawn about these patients. The patient who died with tetanus very probably acquired the disease in hospital, presumably at operation for the abscess, but the treatment could have activated spores introduced at a previous wounding, perhaps that which initiated the infection leading to the abscess.[17] Even if the disease was due to treatment, the infective organism need not be of hospital origin. The 1 patient with smallpox,[18] 1 with measles[19] and 2 with `putrid fever',[20] that is, typhus, are virtually certain to have acquired their infections after admission while another one dying with measles,[21] may possibly have acquired his distemper as a hospital infection[22] although in the former of the 2 patients with measles, the initial disease may have been the cause of death.

While 2 other patients, 1 with putrid fever[23] and 1 with smallpox,[24] may have acquired their infections in the hospital, the timing makes it much more likely that the infections were already being incubated at the time of admission.

Of a further patient dying with smallpox[25] and another with measles[26] it can be said with certainty that their infection was acquired before admission. (However, the latter patient's death may have been wholly or partly due to the `malignant fever', that is, malignant malaria, rather than to measles.)

Thus, of those dying with intercurrent infections, 5 were almost certainly infected after admission, 1 possibly and 2 others improbably so, while 2 more certainly were not infected after admission. Of the 5 almost certainly infected after admission the death of one may not have had the infection as its principal cause.

At this point it is pertinent to remark that the Rules of the Infirmary prohibited the admission of patients with infectious distempers.[27] The Rules did not provide for intercurrent infections, until the 1779 printing, which prescribes isolation of sufferers with smallpox into special premises, the nature of which is unclear and the use of which is dubious.[28] Nevertheless the patterns of incidence through the year suggest no hospital epidemics. This may indicate special management in the care of infectious patients, though we have no direct evidence of this.

It is of interest to note that of the Infirmary's resident Apothecaries completing their service before 1810, 4 died of typhus[29] (Munro Smith's terminology), although none died until after 1773. The Apothecary was the resident practitioner for Out-patients as well as In-patients, seeing some thousands of patients in a year; length of time and numbers of contacts made it statistically more probable that he would be infected than would patients in a hospital used primarily for acute conditions. It may also indicate some change in procedures or circumstances that no Apothecary died in this way until 12 years after the period of this study, and 37 years after the first patient had been admitted. In any case, the change in the fate of the Apothecaries indicates that the year being studied may have been safer for patients then, than for those admitted later in the Infirmary's history.

Thus far we have reviewed 15 of the 86 In-patients who died. Inspection of Fig. 5.2, p.201-3, below, indicates that the deaths of the 71 others are amply explicable by their respective distempers. Some died soon after admission and may be presumed to have been in a parlous condition on arrival. Some others died of chronic conditions which, it is likely, were advanced before admission, since the sufferer from a gradually augmenting ailment is likely, through habituation, to carry on to a worse state before seeking help, than would one more suddenly stricken by disease. It is of great relevance here

Fig. 5.2 DETAILS OF DEATHS WHICH OCCURRED IN BRISTOL INFIRMARY, 1761-2

INDEX NO.	AGE	DISTEMPER (AS IN THE REGISTER)	LENGTH OF STAY BEFORE DEATH INTERVENED (DAYS)
0350M	40	Bubonocele operation performed	1
0773M	66	Contusion of the Breast from a fall from a [???]	1
0145F	48	Pain in the Back Seized with an apoplexy	2
0816F	40	Fever with Petechia	2
0533M	44	Fell from the top of a house 40 foot high & shocked the brain with a contused Thigh	3
0725M	43	Mortification of the Intestinum & Rectum	3
0527M	60	Nervous Fever	3
0258M	18	Putrid Fever	3
0974M	10	Mortification of the Intestine	3
0968M	35	A Bank of rubble fell upon him, Back & Breast violently contused	3
0368M	16	Fever	4
0915M	38	Mortification of the Bowels	4
0733M	63	Vomica Pulmonium	4
0563M	24	Violent inflamation of the Face & gangrene	4
0367M	45	Fever	4
0886F	50	Fever with Petechia	5
0731M	62	Mortification of the Scrotum	6
0195M	25	Hemiplegia & seized with an apoplexy	6
0088M	34	Caries of the Femur Bloody flux	6
0541M	70	Abscess of the Abdomen	7
0222F	63	Atrophia	7
0503F	55	Mortification of the Intestines	7
0059F	26	Miliary Fever	7
0613F	28	Putrid Fever	7
0753F	24	Putrid Fever	8
0094M	60	Mortification of the Leg & Thigh	8
1008F	20	Peripneumonia Notha	9
0308M	26	Wound on the Head Erisipelas on the face	9

Fig. 5.2 (Contd.) 2nd page

INDEX NO.	AGE	DISTEMPER (AS IN THE REGISTER)	LENGTH OF STAY BEFORE DEATH INTERVENED (DAYS)
0210M	36	Seized with the Smallpox	10
0979F	25	Ascities & Anasarca with the mortification of the Leg	10
0778F	24	Pthisis, Peripneumonia Notha & Marasma	10
0413F	38	Atrophia	10
0395M	10	Stone Cut	10
0599M	28	Angina Maligna	10
0564M	62	Putrid Fever & Atrophia	11
0119M	3	Mortification of the Cheek	11
0715F	50	Mortification of the Leg & Angina Maligna	11
0283F	28	Putrid Fever	11
0671F	30	Fever with petechia	11
0446M	14	Contusion of the Back Seized with smallpox	12
0695M	54	Putrid Fever	14
0310M	17	Malignant fever with sore throat. Seized with the measles	14
0264M	40	Hydrops Pectoris	14
0036F	40	Abscess of the Thumb seized with a Tetanus	14
0261F	23	Putrid Fever	14
0466M	40	Pthisis & Dropsy	14
0153M	45	Pthisis & Hydrops Pectoris	16
0363M	50	Atrophia ascities & diarrhoea	17
0250F	49	Ascities Anasarca & Hydrops pectoris	17
0547F	30	Scirrhus & gangrene of the Uterus	17
0455F	19	Ulcer of the Leg Seized with a putrid fever	18
0035F	20	Disenteria	18
0634M	21	Fell into a furnace of boiling lees	19
0957F	63	Disenteria & Atrophia	20
0431F	50	Dropsy	21
0722M	35	Peripneumonia Notha	22
0122M	40	Cancerous tumor of the Neck & Atrophia	24
0771M	42	Peripneumonia Notha	24

Fig. 5.2 (Contd.) Final page

INDEX NO.	AGE	DISTEMPER (AS IN THE REGISTER)	LENGTH OF STAY BEFORE DEATH INTERVENED (DAYS)
0519M	77	Dislocation of the Shoulder & impostumation of the Lungs	24
0428M	61	Abscess in Perinea	27
0136M	45	Ascities, Anasarca & Pthisis	27
0467M	50	Sinus of the Leg and Arm with an atrophia	27
0235M	29	Dropsy Jaundice & Scirrus Liver	27
0387M	60	Ulcer of the Leg	28
0259M	34	A tendon and artery of the left Hand div. Sz. Measles	28
0323F	46	Dropsy	28
0169M	48	Ascities & Anasarca	32
0039M	42	Abscess of the Eye and a caries of the bone of the Nose	34
0418M	50	Abscess of the Liver	35
0930M	27	Dropsy & Mortification of the Legs	35
0497M	56	Pthisis & Dropsy	38
0362F	15	Abscess of the Thigh	41
0650F	24	Rheumatism Seized with a putrid fever	42
0492M	40	Dropsy Seized with fitts	45
0926F	61	Ascities & Anasarca	45
0300M	50	Siphilic Atrophia	46
0295F	40	Ascities & Anasarca	46
0293F	26	Cough Seized with the Measles and angina maligna	56
0057F	23	Epipocele operation performed Seized with Old Passio Iliaca	60
0794M	35	Ascities & Anasarca	65
0307M	47	Pthisis & scirrus of the Omentum	70
0156M	24	Feverr Seized with Smallpox	71
0140F	29	Atrophia	91
0863M	55	Dropsy	100
0303F	36	Ulcer of the Leg Seized with a putrid fever	201
0765F	26	Caries of the Ankle, leg amputated	301

that the general condition of a person deteriorates, even to death, not only from generalised infections[30] but also from local infections[31] and mortification, that is, gangrene or necrosis,[32] or caries of bone.[33] From these local disorders products of bacterial activity may be spread, either from the organisms themselves or from the breakdown of infected tissues. Where the distemper is, like dropsy,[34] a condition which would now be thought of as an effect rather than a diagnosis indicative of appropriate treatment, a serious disorder may have been indicated. Dropsy itself, for example, would be seen by the modern reader of the In-patient Register as probably due to advanced disease of the heart or kidneys. While we cannot know whether treatment could have saved a life that was lost, the information we have about these 71 patients gives no reason to presume negligence or mismanagement.

We would suggest that, of the 15 patients first discussed, 7 suffered iatrogenic (medically induced) death, 4 may have done so and 4 did not. Among the other 71 patients who died every death can readily be explained without its attribution to treatment or admission to hospital. Therefore, unless some of the 71 deaths are thus attributable, the minimum number of iatrogenic deaths is 6 and the maximum 13, that is, 0.6 - 1.3% of In-patient admissions.

These fatalities may be better put into social perspective if they are related to perceived risks. The point will now be made from practice with which the reader may be more immediately familiar.

Patients today are invited to undergo operations which have immediately or within the convalescent period, death rates of 10% or more. On the other hand, there are medical and surgical procedures which we expect never to prove fatal. There is no reason to suppose that patients in the 18th century were unaware that some procedures were dangerous and that some were not. Doubtless they also

appreciated whether admission to a particular hospital or other residential institution, was, in their estimation, likely to lead to a supervening serious, and perhaps fatal, sickness.

Consider for example, cutting for the stone. When the patient (justifiably) had lost any faith he might have had in a non-surgical cure for the stone in his bladder, and when the experienced 100% certainty of agony seemed worse than the 10% probability of death, was it not a useful service to offer the sufferer the possibility of operation? Whatever the statistics show, we should not assume that patients were victims of procedures of which they had no inkling of the risks. Entering one's local voluntary hospital, being cut for the stone, undergoing amputation of the leg, for example, were all events of which the various sequelae must have been common knowledge. As noted in Chapter 1, the Infirmary was not part of statutory provision for the poor, and nobody was compelled to enter it; on the contrary, eligible potential In-patients had to be turned away for want of room. Also, in Chapter 1 (p.40), it has been shown statistically that there must have been considerable awareness in the city of what happened to patients in the Infirmary. Nevertheless, in distress one may often not calculate the odds. Fissell however, sees no reason why a hospital such as the Bristol Infirmary should have been mortally dangerous. She writes:[35]

> Previous generations of historians have questioned whether hospitals were `gateways to death'. The argument seems pointless in the case of Bristol. There is no way to portray the Infirmary as a last-resort institution where people went to die. It had defined itself as an institution for patients who would recover to lead productive lives.

This is misleading for two reasons. First, while the Infirmary refused those who were judged unable to improve with all possible help, it did admit people in a dangerous state of health, who might possibly benefit from treatment. The Rules and the Registers are clear on this.

Secondly, an institution for short-term care, with the expectation of discharging patients in a healthy state, can nevertheless be very dangerous which, as it transpires, Bristol Infirmary was not. Thus, in 1842 the First Clinic Maternity department of the Vienna University Medical Faculty had a death rate of 15.8% and an average death rate of 9.92% for the years 1841-6 inclusive.[36] Although there were some inherent dangers in childbirth 15.8% mortality was far above the expected norm. Confining of patients to the curable, acutely sick is not a sufficient condition for a hospital to be safe. In any case, the argument against the 18th century hospital commonly refers not only to the dangers of treatment but also to the danger of just being there.

5.4 INTERCURRENT DISEASE IN THE BRISTOL INFIRMARY, 1761-2

In connection with causes of death, reference was made to infections acquired after admission. Infections are not the only distempers to become apparent only after admission, but neither of course need the supervention of a further distemper entail death. The risk of intercurrent disease now needs to be considered more generally than as a contributor to mortality and morbidity.

Of the 1015 In-patients, 833 had a single recorded distemper, the remainder having two, three or, in three instances, four. Of the patients with more than one distemper, 26 were recorded with the words `seized with' before the last-named disorder, and are the subjects of Fig. 5.3, p.207. (This number includes the 10 patients who died with this label and have already been discussed in some detail.) The nature of the disorders with which patients were seized makes it certain that this is a formula indicating intercurrent disease, that is, a disease manifesting itself after admission. The question arises whether some patients were seized with an intercurrent distemper, but without the fact being recorded. The

Fig. 5.3 INTERCURRENT DISTEMPERS AFFLICTING IN-PATIENTS AT BRISTOL INFIRMARY, 1761-2

INDEX NO.	AGE	DISTEMPER	LENGTH OF STAY (DAYS).	STATE*
0006F	24	Infarcted Lungs - suppd. Mensium-Seized with Measles	161	Cd.
0011F	42	Hysterics - seized with a fever & sore throat	56	Cd.
0036F	40	Abscess of the Thumb seized with a Tetanus	14	Dd.
0043M	40	Dropsy Seized with an Erisypelas	63	Cd.
0057F	23	Epipocele operation performed Seized Old Passio Iliaca	60	Dd.
0071F	25	Eruptions, seized with a fever & cough	179	Rd.
0083F	19	Fever, seized with Smallpox	66	Cd.
0145F	48	Pain in the Back Seized with an apoplexy	2	Dd.
0156M	24	Feverr Seized with Smallpox	71	Dd.
0179M	19	Rheumatism Seized with Smallpox	56	Cd.
0195M	25	Hemiplegia & seized with an apoplexy	6	Dd.
0210M	36	Fever Seized with the Smallpox	10	Dd.
0255M	28	Fever Seized with the Measles	59	Cd.
0259M	34	A tendon and artery of the left Hand div. Sz. Measles	28	Dd.
0267M	15	Rheumatism Seized with Smallpox	67	Cd.
0293F	26	Cough Seized with the Measles and angina malinga	56	Dd.
0303F	36	Ulcer of the Leg Seized with a putrid fever	201	Dd.
0310M	17	Malignant fever with sore throat.	14	Dd.
0446M	14	Contusion of the Back Seized with smallpox	12	Dd.
0455F	19	Ulcer of the Leg Seized with a putrid fever	18	Dd.
0492M	40	Dropsy Seized with fitts	45	Dd.
0512F	22	Fever, Seized with the smallpox of the confluent sort	38	Cd.
0517M	11	Fracture of the Leg Seized with smallpox	39	Cd.
0566M	40	Hematocele, Seized with a fever	28	Cd.
0650F	24	Rheumatism Seized with a putrid fever	42	Dd.
0929F	19	Fever & Seized with Fitts	38	Cd.

* State on discharge. Cd.= Cured; Rd.= Relieved; Dd.= Dead

register shows a clear distinction between single distempers, multiple distempers, and multiple distempers with one of which the patient is `seized'. In this third group the intercurrent diseases are either infections (21 patients), diseases of sudden onset (4 patients), or recurrence of an old distemper (1 patient). Of the multiple distempers noted without the term `seized with', on the other hand, in only a few patients is it at all probable that the last-named distemper would have arisen intercurrently (pleurisy with herpes, for example).[37] In other records the two distempers are almost certainly aspects of a single disorder (such as cough with hectic fever).[38] The most important reason, perhaps, why we should take the term `seized with', or its absence, to be indicators with constant value, is that the Register was the responsibilty of one man, the Apothecary, the full-time resident practitioner, who may be assumed to have been consistent in his favoured mode of recording. (We see here the origin of the later title `Registrar', not then given to the Apothecary however, but now to his successor, the most senior resident physician or surgeon.)

Thus far 10 of the 26 patients who were both `seized with' an infectious distemper and died (though not necessarily as a result of this infection), have been reviewed, as has the patient unfortunate enough to be `seized with' `Old Passio Iliaca' and who also died. Of a further 11 who were seized with infections, 1 was `Relieved' and the other 10 `Cured'. Of these 11, 5 had smallpox, one of them the especially dangerous confluent variety, and the recovery of this last patient, already otherwise sick with `fever', may speak well of the general care given.

Since the shortest total stay of any patient remaining alive after intercurrent infection with smallpox was 5-6 weeks, and since the seizure with this disease could have been at any time that allows for recovery before discharge, no inference can be made that an infection was acquired before or after admission. (The matter is, of

course, different when the discharge state is death terminating the intercurrent disease, as for some patients whose deaths have already been discussed.)

If all intercurrent infections are considered, 21 patients were affected. The calculation already made from the records of patients who died suggests that only about one-half of all those infected received their infection in the hospital. About one-half of all those infected died. A full assessment of the danger would need to include consideration of comparable morbidity and mortality outside the hospital, which perhaps cannot be ascertained. In general, however, the Infirmary does not appear to have been a strikingly active nest of communicable disease. The probability of catching something, whether fatal or not, was of the order of 2%.

Two patients were seized with `apoplexy';[39] (cerebral haemorrhage or thrombosis, it may be inferred). Both died. Of the 2 seized with `fits',[40] 1 died but the other recovered.

As noted in Appendix 1, Richard Smith's *Biographical Memoirs* include many snippets of information which afford insight into medical practice at the Infirmary over a very long period and Munro Smith has made much use of these *Biographical Memoirs* in compiling his own history of the Bristol Infirmary, as he himself explains.[41] Munro Smith has been used here to reconstruct and examine some of the therapies in use at the Infirmary in the 1760's.

The 18th century was an era of depletory (reducing or evacuating) treatment, the `low diet' being part of this therapy. Purging was frequently resorted to and bleeding still practised despite the decline of Galenism over the previous century. Munro Smith writes that bleeding was both popular and routine, and seen as a panacea for all diseases.[42] Twelve ounces was the usual amount taken and, by modern judgment, should cause neither harm or benefit to

the patient unless the patient was already anaemic or the treatment repeated too soon. Its use in the Out-patients in the 19th century is vividly described by Munro Smith.[43]

Operations were horrific, with the only anaesthetising agents available being either brandy or laudanum (a preparation of opium), but the Infirmary surgeons had a good reputation for their manual dexterity and, as Munro Smith says,[44] 'Many of the old surgeons were, as a fact, very expert with their hands. *Chirugeons* in the true sense of the word'. (Attention has already been drawn in Chapter 1 to the expertise of a number of Bristol Infirmary surgeons in performing lithotomy operations. This operation required an opening into the bladder from the exterior, between but not into the front and back passages. This was done with a single fast cut, followed quickly by hooking out the stone with a specially shaped instrument.)

5.5 THE *PHARMACOPOEIA IN USUM NOSOCOMII BRISTOLIENSIS*

The Pharmacopoeia[45] contained almost 200 prescriptions with about half as many additional prescriptions being noted as variations. Two bound copies were kept in the Apothecary's shop.[46] These prescriptions have been interpreted as to actual *materia medica* and as to inferred use with the help of several guides, including Thomas Sydenham[47], Richard Mead[48], Nicholas Culpeper[49], C.F.Leyel[50], Lewis and Short's Latin dictionary, the compilers of the Oxford English Dictionary and the Encyclopaedia Britannica (11th edition), together with their translators as necessary.

After the formulae had been examined, it became possible to make certain generalisations. The metals mercury, antimony, lead, tin, and iron all appear. This is ultimately due to the influence of Paracelsus (c.1490-1541), who introduced metallic treatments, and to the decay of Galenism, with its almost entirely herbal *materia medica* (the change occuring throughout the 16th and 17th centuries). Some mercury preparations are undoubtedly for

syphilis but the number of different mercurial preparations raises the question of whether it had, at this time and place, other uses. Some mercurial formulae have not the mercury compounds but the metal itself. This may be due to the influence of Dr. Thomas Dover (see Chapter 1). Mercury and its compounds continued to be used in the treatment of syphilis into the 20th century when also calomel (mercuric chloride) was often prescribed as a laxative. Antimony is a vermifuge (a drug used to expel worms from the intestinal tract) and at least one of its compounds, tartar emetic, also continued in use to the 20th century. Lead compounds were, in general, applied as external astringents, for example, to haemorrhoids, and tin, in one formula, seems simply to have been a means of making an amalgam with mercury which would thus make the mercury more managable than when liquid, if it was to be administered medicinally.

The herbal formulae did not include prescriptions with a multitude of ingredients (such as `Venice treacle' with its 65 ingredients) which were still in use elsewhere in 1692.[51] The plants used, many of them imported, were not dangerous, and most would have been effective for their purpose, remaining in use for a further century-and-a-half. One formula is that of the commercially successful Beecham's Pills of our own time! Colchicum in gout, aloes as an aperient, opium for pain, and Peruvian bark in ague, are examples of useful plant products which feature in the *Pharmacopoeia in usum Nosocomii Bristoliensis*, which continued in use long into later years, and which are certainly effective.

Unpleasantly tasting drugs were always compounded with substances concealing their taste. Conserves of orange peel, red roses or dog roses are named in the Pharmacopoeia. Indeed, a pleasant flavour could be there, it seems, just for pleasure. Thus one *electarium* (medicine to dissolve in the mouth) in which the active drug was opium, had nutmeg sufficient to give the *electarium* the title *aromaticum*, nutmeg's main pharmaceutical use being as flavouring,

although the mixture included other substances to hide the bitterness of the opium. A pleasantly flavoured thick syrup dissolved slowly in the mouth, giving a taste of nutmeg, must have been no bad way of soothing one's pains with opium. Similarly, sulphur was given in rose syrup, which must have had some pleasantness lacking in the later brimstone and treacle of the 19th and 20th centuries. Foul-tasting valerian (considered to calm the nervous system and therefore the psyche) was made less objectionable with a mixture of rose jam and orange peel syrup (although the 20th century panel patient had to accept valerian in all its unpleasantness) and the taste of castor oil was disguised with peppermint. (For the maternity patient of the 1960's, past her due expected date of delivery, this would have been a great advantage. Not to have to drink 2oz of the substance with its taste undisguised would indeed have been welcome!) Medication in pill form was also in use, for example, Pilulae aloeticae (bitter aloes for use as an aperient); much pleasanter to swallow in pill form than as a liquid.

The range of drugs does not, at first sight, lack any that might be expected, and formulae which would be expected to have a similar action, and different only in an inactive ingredient, may reflect differences in the idiosyncrasies of physicians. Therefore, from the Pharmacopoeia one may infer that 1) expense was not the chief criterion, 2) pleasantness, as well as pharmacological action, was catered for, and 3) there was no substantial difference from what one might expect a physician or apothecary to consider suitable for his own family. (Paying patients are another matter, and might have been conned by over-elaborate therapy, as also happens sometimes today.)

Thus, in general, the evidence we have of how patients were treated with regard to remedies suggests a proper respect for the patient, with nothing second-best. This reqires certain attitudes on the part of, first, healers who thought it mattered and, secondly, committee members who nowhere (as far as this study has found)

objected to this expenditure. (The Garlick affair, referred to in Chapter 2, reveals a single bout of `cuts' attempted by one man, but this was not directed primarily at therapy and was roundly and soundly repulsed by all the other committee members.)

5.6 THE BENEFITS OF TREATMENT

To turn from the risk of harm to the patient to seek what may have been possible therapeutic benefits, is to engage a certain methodological difficulty from the outset. Some distempers have a poor prognosis whatever the treatment, while others will almost invariably heal without intervention, requiring only the *vis medicatrix naturae*, nature's healing power. Even at these extremes, however, treatment can be of value, reducing pain or other distress, making possible the refreshment that sleep gives, or guiding the body towards a better state than might otherwise result after the active disease process is passed. Of such treatment the register tells us less than does, say, the Pharmacopoeia.

On attempting to assess the efficacy of treatment of those patients whose distempers may be expected to respond to it the difficulty remains, since the time from admission to discharge will naturally vary between patients with the same distemper, and the Register does not, of course, tell of controlled clinical trials. We can however, obtain some notion of the efficacy of treatment, if the distemper and treatment are known, if we have a reasonable expectation of what the outcome of such treatment would have been, and if we consider, but not uncritically, the state on discharge as recorded in the Register.

Here a further difficulty arises. We have little information about treatment of specific individuals. For 64 out of 1015 In-patients, (but for no Out-patients,) an indication of treatment is noted in the Register as part of the entry. Thus we may find `Syphilis - salivated',

indicating that standard mercurial treatment was used. This kind of information, available for fewer than 1 in 16 of In-patients, and very unevenly distributed among the distempers, is of a usefulness more limited than seems desirable for the present purpose. Nevertheless, treatment may often be inferred with a fair degree of certainty, if one assumes conformity with the standard practice of the period, and within limits set by the Pharmacopoeia. With these limitations in mind, we shall now consider therapeutic efficacy among patients with distempers of four kinds: injuries, leg ulcers, certain fevers, and syphilis. The first three of these four groups are taken because they are fairly large. The fourth group, syphilis, is included as it is an example of an identifiable disease rather than a title of a syndrome (which some might now consider heterogeneous catch-alls), or simply a symptom, such as `cough'.

Injuries During the twelve months 209 In-patients and 201 Out-patients were treated for injuries. Fractures of limbs account for 37 of these In-patients but only 3 of the Out-patients. Five of the fractures (all In-patients) were compound and yet the state of each patient on discharge is described as `Cured', despite the infection to which a compound fracture is liable. One has only to consider the difference between a fracture that has been set and the disabling angle of healing or false joints that are likely without treatment, to see the value of surgical attention. Two women were trephined[52] as part of their treatment for a fracture of the skull, in the case of one of the women in two places. Both were `Cured'. When one considers the dangers to the underlying brain due to bone fragments, or by depression of a broken bone, one must suspect a useful skill. Long-term care seems also to have been effective; a four-year-old girl was admitted as a Casualty with `Burnt Legs Arms Breast & Face' and was discharged `Cured' in the 27th week of her stay.[53] (Doubtless the injury precluded by its severity and urgency the application of the Rule that the Infirmary should not admit children.) The general point

can be made, that inspection of the Register entries concerning injured patients leads to the conclusion that all or most of them would probably have benefitted from the attentions of the surgeons.

Leg ulcers The surgeons' attentions appear to have been beneficial also to patients with leg ulcers. There are 210 patients with leg ulcers, 124 In-patients (108 `Cured', 3 `Relieved', 6 `Out-patients', 3 `Dead', 3 `Irregularly' and 1 `Own Request') and 86 Out-patients (64 `Cured' and 10 `Relieved', 2 `In-patients' and 10 `Non-attendance').

In connection with the treatment of this condition it is of interest to note the 1797 work of Thomas Baynton[54] (already referred to in Chapter 4), whose totally rational improvement in treatment achieved some fame and was warmly commended in the Edinburgh Dictionary of Medicine and Physiology dated 1803.[55] Although Baynton's writings throw no direct light on Bristol methods a generation earlier, they indicate that leg ulcers could be taken as a field for the advancement of the surgeon's art, rather than as a matter merely for unthinking repetition. (Incidentally, Baynton's method could well have reduced the pain.)

To see what true benefit there might be in treatment generally and, with particularity, to leg ulcers, we need to give a meaning to the word `Cured'. The ulcer is a raw area where the skin has died, often if not always because of a local fault in the blood circulation, commonly in association with varicose veins. Treatment in the 18th century was directed towards covering the ulcer and applying such substances as might be considered favourable to healing, while the circulation might be aided by bed rest, since blood returns to the heart more easily through leg veins less impeded by gravity than when the legs are standing or dependent. The pressure of bandages might also be favourable to venous flow, by reducing the volume of stagnant blood. Under such conditions the skin over a healed ulcer would naturally tend to ulcerate again after

the end of treatment if the underlying defect remained, but recurrence would not have been invariable. When an ulcer was said to be `Cured', we may take it that the continuity of the skin had been restored, but not that the leg was out of danger from a recurrence of the disease. An ulcer of the leg is always painful and may be foul. It seems likely that a `Relieved' ulcer was clean, with greatly reduced pain or none, but not completely healed across. In view of the pain, discharge, and even foulness of an ulcer, there was clearly benefit to be had from treatment, even if further attention, perhaps at the Infirmary, would be necessary in the event of a recurrence.

Fevers A third field of therapeutic endeavour was fevers. Some fevers accompany local inflammatory processes such as abscesses and chest infections. These we exclude from the present discussion; also excluded are fevers absent on admission. After these exclusions we are left with four main groups of fever (see Fig. 5.4, p.217 below), putrid fever, those fevers which would now be identified as malarial, non-specific fevers many examples of which are noted in the Register simply as `fever', and finally the specific fevers such as whooping-cough and measles (prohibited from In-patient admission),

To classify fevers from the Register is not possible with certain exactness. For example, we have taken `fever and cough' to indicate a localised cause, to which the cough was also due, although the fever (and the cough perhaps) may have been due to a generalised disorder. Again, `slow fever' has been taken in its broad, non-specific sense, although Mead in 1751 made the term synonymous with `hectic fever',[56] which appears as such in the Register and is typically associated with the chest disorder, pulmonary consumption, now more commonly referred to as pulmonary tuberculosis.

As the Rule against admitting patients with contagious diseases was otherwise applied absolutely, putrid

Fig. 5.4 FEVER ADMISSIONS TO BRISTOL INFIRMARY, 1761-2

Numbers of patients with fever on admission, excluding those with localised causes of fever, such as abscesses or chest infections. (Patients with fevers diagnosed after admission are also noted in Figure 5.3.) The Rules of the Infirmary prohibited the admission as an In-patient of anybody with an infectfious disease, but putrid fever was not then recognised as transmissible. The fevers which appear to be what would now be seen as malarial are further classified in Figure 5.5

TYPE OF FEVER	IN-PATIENTS		OUT-PATIENTS	
	NO.	STATE ON DISCHARGE	NO.	STATE ON DISCHARGE
Fevers such as may retrospectively be classed as malaria	30	28 `Cured' 1 `Dead' 1 `Own Request'	55	54 `Cured' 1 `Irreg-. ularly'
Putrid fever (typhus)	14	7 `Cured' 7 `Dead'	0	---
Whooping cough	0	---	13	13 `Cured'
Measles	0	---	1	1 `Cured'
Non-specific fevers	66	61 `Cured' 4 `Dead'* 1 `Own Request	92	89 `Cured' 3 To`In-patients'

*2 of these deaths were probably due to an intercurrent infection with smallpox

Note: The 3 patients transferred from Out-patient to In-patient care all made the change in less than 1 week, and therefore contribute to both In- and Out-patient totals. Individual patients with non-specific fevers number 155 in all.

fever was evidently not recognised as contagious. This particular fever underwent a change of nomenclature in 1759 when Sauvages used the word `typhus' for it[57] (the name we still use) but it was not recognised as contagious by Cullen until 1769 at least.[58] It was, however, a most dangerous disease. Of the 14 patients admitted with it half died, while the 3 who were `seized with' it after admision all died. Perhaps these last 3 were already in a weakened condition and unable to put up much resistence to the infection.

The fevers which, for a reason to be given, we anachronistically group as malarial, are specified in Fig. 5.5, p.220 below. At this time the word `malaria' (bad air, written thus, *`mal'aria'* in the Italian), was the fever of the Pontine Marshes, which was not identified with, say, ague in Bristol. Indeed, the term `malaria' entered medical literature in English only in 1827 and, while it may be hard to find `swamps' in Bristol, parts of the city are built on drained marsh land.

Almost certainly the malarias and non-specific fevers to be examined would have been treated with a preparation of cinchona. Cinchona had come to European medical notice in 1638 with the use of the Peruvian bark (as cinchona was then called)[59] for the treatment of the Countess of Cinchon, wife of the govenor of Peru, and favourable results of its use in fever were reported by Thomas Sydenham between 1666 and 1676.[60] (Quinine was isolated from Peruvian bark in 1820 but the specificity of this drug for malaria was not appreciated until after Laveran's discovery of the malaria parasite in 1880.) Richard Mead, in 1751, takes cinchona to be standard *materia medica* in certain fevers, and correctly refers its use to Sydenham's teaching.[61] This drug is named as `decoctum Peruvianum' in the Bristol Pharmacopoeia.

Now, if cinchona was used for patients with fevers (and it is difficult to believe that it was not), and if the

fevers so treated included those which can be seen retrospectively to have been what we would call malarial, that is, those in Fig. 5.5, p.220, then the meeting of the treatment with the distemper in these 85 patients must have done at least some good. It is true that the disease may not have been eradicated from the patient, and that `cures' were sometimes, or even perhaps usually, remissions. Nevertheless, even with the least efficacy of treatment the dosage being (let us suppose) inadequate for greater effect, the distemper would certainly have been lessened in severity and modified towards a diminution of the patient's suffering. Further, there is no need to assume that this supposition of the least possible effect of treatment with cinchona always, or ever, corresponded to events. The point is, that since this is the worst possible outcome, all 85 patients must be assumed to have received some benefit.

Sufferers from both whooping cough and measles, due to the contagiousness of the infection, were excluded from the In-patient wards by the application of the hospital Rules. In some instances of these diseases however, patients were already excluded by virtue of their youth. In the event, all 13 of the children with whooping cough and the single child with measles were discharged from the Out-patients as `Cured'.

Syphilis The last group of patients now to be reviewed is those suffering from syphilis. There is no doubt that the Register distinguishes syphilis from gonorrhoea, a point worth making since, although Sydenham had seen their distinctiveness and reported it in 1680,[62] Richard Mead, as late as 1751 writes of gonorrhoea in a way that leaves open the possibility that he takes them to be forms of a single infection.[63] John Hunter, adding experimental to Sydenham's clinical evidence, proved their distinctiveness in work published in 1786.[64] Venereal disease, according to the Rules of the Infirmary, was to be excluded from the wards.[65] However, 38 of the 55 patients treated for syphilis were warded as were a further 2 of the 15 patients presenting

Fig. 5.5 ADMISSIONS TO BRISTOL INFIRMARY, 1761-2 OF PATIENTS WITH DISTEMPERS NOW CLASSIFIABLE AS `MALARIAL'

The first column shows the distempers as named in the Register. Except for the three patients to which reference is made in the footnotes, the state on discharge is invariably `Cured'.

	IN-PATS.	OUT-PATS.	TOTAL
Ague	0	4	4
Ague and dropsy	1	0	1
Ague and/with fever[1]	17	26	43
Ague and fever of long standing	1	0	1
Ague and fluor albus	1	0	1
Ague Kentish and obstruction of the liver	1	0	1
Phthisis and ague	0	1	1
Dropsy, fitts, fever and ague of the head	1	0	1
Anomalous intermittent	2	9	11
Intermittent	0	4	4
Intermittent fever	1	4	5
Intermittent fever and rheumatism	1	0	1
Intermittent fever with dropsy	1	0	1
Malignant fever with sore throat Seized with measles[2]	1	0	1
Quotidian	1[3]	1	2
Tertian	1	6	7
TOTALS	30	55	85

Notes:
1. One Out-patient, (a 50-year-old man from St. Nicholas) was discharged for `Irregular' behaviour,
2. For this patient, who died, an entry appears in Figures 5.2 and 5.3 also (Index No. 0310M).
3. This patient, a 45-year-old man from Castle Precincts, discharged himself (`Own Request') after 3 days.

with other venereal infections. Lest it be thought that the Rules were of no account, it may be noted that 4 In-patients suffering from syphilis were sent away from the Infirmary on the ground that their admission was `Against Rules'. During the entire twelve months only 6 patients were thus discharged, the other 2 involving a case of tinea (more properly an Out-patient distemper) and a pregnancy.

Out of the 17 syphilitic Out-patients 10 were discharged as `non attend'd',[66] a discharge state which gives no indication concerning state of health. Of these 10 patients 6 were male and 4 female and all came from either the city itself or adjacent parishes. None were sailors, strangers, or others without a named parish of origin. It is likely that we have here patients who, as happens today, cease to seek cure once they had relief from their presenting symptoms, or who considered the treatment worse than the disease. Of the 38 In-patients, 1 man, admitted with `Siphilic Atrophia', died and another described as suffering from `Siphilic ulceration on the Buttocks' was discharged for behaving `Irregularly' (that is, in some way acting contrary to the Rules of the Infirmary). Another In-patient was discharged at his `Own Request' and a further 2 were transferred to Out-patients (although they do not enter the Out-patient register, at least in the period under investigation). Thus the state of 19 of the syphilitic patients on discharge was `Against Rules', `Non-attend'd', `Dead', `Own Request', `Irregularly', or `Out-patients'. The other 36 patients with syphilis were recorded as `Cured' by their discharge date, apart from the single exception of a transfer from the Out- to the In-patient facility. This patient was not able to enjoy the hospitality of the Infirmary for long - he was one of the 4 discharged as being admitted against the Rules!

Since between the primary and secondary stages of syphilis, and between its secondary and tertiary stages, there may be periods without symptoms, an apparent cure may be only a remission. Here again, we may seek probabilities

from the treatment used. As noted, there is occasionally and irregularly the naming of treatment in the Register entry for this distemper. For 23 patients with syphilis the word `salivated' is appended to the name of the disease. This refers to the then standard treatment of syphilis by the use of mercurial compounds and which was probably used also for those patients whose entries did not include the word `salivated'. Mercurial compounds would have been administered until the dosage was just sufficient to cause abnormally abundant salivation, this being the knife-edge between therapeutic adequacy and unacceptable toxicity. Although the oldest interpretation of the running of saliva was that it evacuated the peccant humour of the disease, it would be seen to-day as a symptom of mercury poisoning. In fact, by aiming at salivation without, it was hoped, other toxic symptoms, the amount of mercury required can be therapeutic without its causing the cure to be felt as worse than the disease. However, sometimes this treatment does lead to further results of poisoning, such as teeth falling out. Getting it just right for each patient is a task for the physician's art. Mercurial treatment was certainly effective against syphilis in that it stayed the disease and allowed recovery. Whether, in any particular patient, recurrence had been prevented is less certain, and even after two years without symptoms, a recrudesence could have been possible. However, this fact was not appreciated in the 18th century and it would have been totally honest to use the word `Cured' where we, with benefit of hindsight, might have used the word only for an eradication, making a distinction for which there was then probably not even the conceptual background. Nevertheless, eradication of the infective organism from the body, by mercurial treatment, was a possibility acknowledged by Edmund Owen in the early 20th century,[67] so that we cannot suppose that it never took place in the 18th. During this period guaiacum, a resin from the West Indian tree, *Lignum vitae*, was also in use for the treatment of venereal infections, but its use declined early in the 19th century to be replaced by the internal use of Lugol's iodine for causing the softening and

disappearance of the hard masses (gummata) of the tertiary stage of syphilis. (This improves access of mercurials - or, for example, penicillin - to the infecting organisms.)

If one considers the numerous irremediable disorders, first of the body and then of the mind, by which syphilis is likely to conclude its course if unchecked, there can be little doubt that the treatment at the Infirmary was, on balance, to the patient's advantage, especially since further treatment, as needed, to check any recrudesence must be presumed possible.

Why the Rule prohibiting the admission of In-patients with venereal disease was so extensively broken is another matter. The Rule itself may have been cosmetic towards the public, or for peace at a Committee meeting. (Discretion by the physicians is not allowed for in the Rules.) Nevertheless the Rule was occasionally applied.

5.7 CONCLUSIONS

The Register was probably not intended as a record for the later benefit of medicine and surgery, and it is not surprising that the weaknesses and strengths of medical care can seldom be inferred from it with certainty. Nevertheless, the possibilities which it excludes and the probabilities which can be inferred from it can be the basis for assessing comments quoted in the opening section of this chapter. Our findings support Sigsworth's generalisation that consideration of actual records and of patients gives a more favourable picture of 18th century hospitals than is suggested by writers such as Buer, McKeown or Brown, who assert that these hospitals were positively harmful. In reply to Webster's concession that the hospitals `brought genuine relief to a modest number of In-patients', we would ask whether Out-patients might not also have benefitted, and whether the number of benefitted In-patients in Bristol was really modest, especially in view of the high rate of admission in proportion to the population. Hospital

infection and the dangers of medical and surgical treatment constituted an overall risk of iatrogenic morbidity and mortality which is, in relation to the distempers treated, not excessive by the standards of any period, and which is likely not to have outweighed in patients' minds the benefits of admission. Such benefits were, for a large proportion of patients at least, a reduction in suffering, effective assistance with recovery, and even saving of life.

Concerning method, we would suggest that this study shows how the intensive investigation of medical data, even over a short period can contribute to wider social investigation. Medical particularities may not lead directly to generalisations, but they can contribute to them and can correct some statements claiming universal validity for themselves. The aims, techniques, and outcomes of therapy are a part of social history.

CONCLUSIONS

CHAPTER 6

Conclusions and prospects

6.1 POWER AND THE POOR

The purpose of this work has been primarily neither to contend with nor reply to other workers. However, in reviewing the study, I find that replying to another worker conveniently brings together and emphasises some of the findings. I will therefore now note how these differ from those of Mary Fissell, the author of the only comparable study of the Bristol Infirmary.

One of the main results of this thesis has been to revise recent research on the foundation and purpose of the Bristol Infirmary and here Mary Fissell's work is relevant. However, I contend that Fissell's research has been influenced so heavily by Foucault's[1] views of the origins and purposes of institutional medicine in a later period as to render her conclusions suspect. As earlier chapters have demonstrated, there are dangers of interpreting the practices of a mid-18th century hospital in the light of developments associated with a period after the French revolution. A careful examination of the available evidence reveals the dangers involved in conflating developments over a long period of time for the sake of identifying long-term trends. This study has revealed the difficulties involved in superimposing knowledge, derived from a slightly later period and another place, on a single institution.

Specifically, my analysis differs from Fissell's in four central respects. First, it is wrong to assert that the Infirmary was created for the purpose of complementing the activities of St. Peter's Hospital, an initiative of the Bristol Corporation of the Poor, in providing for the

destitute poor. On the contrary, evidence reproduced here demonstrates that the prime responsibility of the Infirmary was with the section of the population that worked for its living - which relatively few paupers were capable of doing. The chronically sick were specifically excluded and the age range of both In- and Out-patients indicates that the elderly remained outside the main purview of the Infirmary's activities. When we recall that age and infirmity were intimately linked both with poverty and with each other in this period (as in most others), the very different clientele served by the Infirmary indicates strongly that it had no association with the activities of the Poor Law at all.

Second, and closely linked to this, Fissell's assertion that the Infirmary was primarily concerned with the moral reform of its patients is not supported by any evidence I have been able to find - save in the one sermon, preached by Tucker, which is clearly untypical and which Fissell misrepresents. The patients were permitted to take their own discharge (the Infirmary, unlike St. Peter's Hospital, having no legal authority to detain them), were at considerable liberty during their period of stay, and experienced a standard of comfort probably above that found in the domestic circumstances of some, at least. The median 5-week stay of its In-patients would not have permitted the reform of attitudes and morals of an adult Bristolian. Further, Fissell's account is very partial in its use of evidence from the sermons; careful reading reveals that the notion of `reform' and the extension of social control (if thus it can be characeterised) cuts both ways. If the poor were to be rendered sober, thrifty, regular workers, the rich were to be constantly reminded of their social and material debt to their inferiors and required to pay for it through their subscriptions to the Infirmary. The acquisition of wealth without reference to social obligation was just as sinful as riotous or drunken, insubordinate behaviour. Civic duty on the part of both rich and poor was

thus bound together within the Infirmary's rules and practices.

This analysis leads to a third objection. Fissell does not discriminate between different forms of voluntary hospitals; her analysis thus ignores the municipal context within which various hospitals were established and assumes an unity of purpose that they did not possess. In fact, the Infirmary in Bristol served the requirements of an increasingly prosperous, trading community characterised by a high degree of religious nonconformity, which might well have proved more politically divisive had joint ventures such as the Infirmary, not served to unite the citizens in projects of mutual benefit. Here, no single religious establishment is served, as in Winchester and, although the Infirmary might attract students eager to learn the latest surgical techniques, it was not founded with teaching as a major consideration, as was the Edinburgh Infirmary. This thesis has argued that at least two separate strands of hospital development can be perceived within the 18th-century voluntary movement. Beyond this it is appropriate to appreciate the diversity which existed between the particular towns involved. While existing hospitals might be taken as `models' for development, local circumstances and politics were powerful influences in determining subsequent development.

Finally, the research here has demonstrated the dangers of trying to locate the rising power of the medical profession in too early a period. In 1761-2 it is clear that the Subscribers continued to exercise considerable powers over the operation of the Infirmary. They decided who was to be admitted, they controlled the Infirmary's finances; through the system of Visitors they could learn of any complaints from the patients. While expertness in particular treatments was evidently playing a greater part in raising the Infirmary's reputation, the role of the Subscribers within the wider community should be recalled - as employers, local businessmen and owners of wealth. These

were the only people who could afford doctors and their good opinion was therefore extremely important to medical practitioners in terms of the introductions they could offer and the recommendations they could confer. The professional independence of the medical profession lay far in the future and cannot be read into the situation in Bristol at this time. Given that Fissell[2] explicitly fits Bristol Infirmary, inaccurately, to a model by Foucault, it is relevant to note that the latter's concern with medical provision refers to a period beginning about a quarter of a century later than the year used in the present study.

Beyond these considerations, set out by way of reply, some related specific findings may be mentioned. Power lay in the hands of 570 benefactors (that is, Subscribers or large donors), 1 in 8 of whom were women. The benefactors acted as Trustees, Governors and House Visitors, and had responsibility, through the Treasurer, for an outlay of around £2,700 per annum. The provision for the patients, whether in bed, board or therapy, indicates neither stinting nor imposed hardship.

There is no certain evidence for a tendency for patients to come from any one part of the city. The proportion of patients from within the city was 82.5%, 10.6% being from the suburbs and nearby parishes, and 6.9% from farther afield and with a catchment area that stretched from Ireland and Scotland to Germany.

The modal age group of In-patients is 20-30 years and of Out-patients 30-40 years. For In-patients the sex ratio is female:male 40:60 and for Out-patients 54:46. The only conspicuous sex difference according to distemper is the preponderence of males among those with injuries.

Out-patient admissions are maximum in early summer, with a lesser peak at midwinter. In-patient admissions show less marked peaks, and at slightly different times, probably because of the effect of bed-occupancy on

damping swings in the rate of admissions. Both injuries and fevers, with In- and Out-patients aggregated, show a summer peak and a spring minimum. Out-patients whose distempers were recorded as `cough' showed a very marked seasonal peak in May, with a minimum in September, and a marked peak in the 30-40 years age range.

A large proportion of patients was admitted with conditions for which contemporary treatments would be expected to yield cure or marked improvement and an analysis of deaths in relation to clinical condition indicates that the Infirmary may not in itself have been a great danger to patients. Indeed, the evidence is in favour of supposing that a belief that the benefit of admission outweighed the danger of admission must have been well-founded in experience, given the high proportion of Bristolians who were patients, that is 7.4% of the population altogether and almost 2% as In-patients, in one year.

Among the matters which these findings raise for discussion is the part that can be played by non-professional power in the delivery of health care, the therapeutic efficacy of 18th century hospital care, and the implications of details of care for inferring attitudes to patients. Attention will then be given to the relation between interest and ideology or religion in public giving, together with the social function of public giving. The usefulness of classifying early voluntary hospitals rather than lumping them together in one `Movement' will also be discussed, and, finally, attention will be drawn to the method used in this study.

6.2 THERAPEUTIC EFFICACY

It has been shown that admission to Bristol Infirmary in 1761-2 was not an obvious hazard to health. The probability of avoidable intercurrent infection could be assessed only if we know the incidence of similar infection outside the Infirmary. The exhaustive use of the In-patient register

(as distinct from sampling methods) has enabled two investigations to be carried out. One of these shows that there is little certain evidence of death or disease due to treatment. The second is an examination of the distempers and the numbers suffering from each, together with what is virtually certain of the treatments used, either from the Infirmary Pharmacopoeia, from what is known of contemporary practice, or from explicit notes in the Registers.

From this analysis of the Registers it appears that most patients, although not all, would have benefitted from the treatment used. The claim according to the Register that a patient was discharged `cured' or `relieved' is, the evidence presented here suggests, always reasonable, seldom, if at all, incredible, and often probable. While the Infirmary was for `curable' patients, this explains neither the low level of danger from disease supervening after admission nor the known efficacy of treatments in use.

In this connection it is relevant to remember that what we know of medicine and surgery in the past indicates that those who practice it have, since ancient times, been able often to control pain, to speed recovery, to minimise residual disability and to provide correct prognosis, even when they could not cure. Effective medicine did not begin with anaesthetics, bacteriology, antibiotics or any other such advance of the last two centuries, nor have ineffective medicine and surgery ceased with these and other modern developments of undoubted utility. (`Iatrogenic disease' is a 20th-century term and a major group of 20th-century disorders.)

The efficacy of treatment in Bristol Infirmary does not imply that, either in Bristol or elsewhere, treatment was always as efficacious as in modern institutions. Neither is it an argument against the benefits of admission to the Bristol Infirmary in 1761-2 that this or another hospital at some later date may have become more or less dangerous, as an environment or because

of treatment used. Nevertheless, knowledge is cumulative and, in that respect, there can be an inevitability of progress over a long period.

6.3 RESPECT FOR PATIENTS

Provision for the patients showed respect for their persons. As one example of this we may take the flavourings, some evidently expensive, used to make medicines palatable, as doubtless would have been prescribed also for the rich, although some of the more unpalatable materials (e.g. valerian or castor oil) were used without palliation for the common patient in the early 20th century. The inventories indicate a similar attitude.

That the labour of the poor is the source of the wealth of the rich was freely admitted in front of the patients; demands were made of the rich to act in the light of such knowledge. The poor patient had the right of complaint. Social control was at the level usually, if not always, considered necessary in all ages for the effective, undisrupted running of a hospital, school or other institution which aggregates people for a special purpose. Indoctrination was by exposure to prayer and access to the Scriptures, less than which would scarcely have been deemed proper in any respectable household. The relation of benefactor and beneficiary implies condescension, and gratitude was expected. Nevertheless, it seems fair to say that the patient was, if we use the words in the modern sense, the subject of charity as well as the object of charity, appreciated as a person as well as the target of another's deed.

The attitude of Subscribers towards Infirmary patients was not necessarily that of ratepayers towards the recipients of medical help from the Corporation of the Poor. (It has been a feature of the present study to show the differences between the two institutions.) Nevertheless an inventory of St. Peter's Hospital in Bristol, and the Rules

already noted on the control of patients there with epilepsy or violent insanity, indicate humanity, and the exact conditions imposed in the workhouse (to which one could be legally consigned, as one could not to the Infirmary) require historical investigation. Nobody, one assumes, would infer conditions in this mid-18th century workhouse from what is known of workhouses after 1834, especially as there was a change in avowed purpose, from training to control or even punishment.

The attitude of Subscribers towards patients raises a matter of some general interest. It was clear that it was considered good to get valuable toilers back to productive life. Conscience might also have yielded a motive among those who realised that the poor were the source of the wealth which made benefaction possible. For some, no doubt, there was also the anticipation of heavenly reward. Beyond these considerations, may there not have been a further motive, no less powerful for being difficult or impossible for the motivated one to express in words? The sheer act of giving, apart from interest, conscience or reward, is pleasurable. It can be done for its own sake; the saying of Jesus[3] that `It is better to give than to receive' is perhaps a psychological truth, not a paradox. (Among Jews it is normal for a beggar to consider himself as doing a favour to the donor and a similar attitude is reported by those familiar with life in India.) Thus it is that the patients may have satisfied a psychological need of the Subscribers. In this way the communal bonds between the two classes of Bristolians would have been strengthened. In such circumstances it is unwise of the social historian to calculate only evident advantage and disadvantage, or assume that all material advantages are maximised. Material advantage may be set against other satisfaction by processes not entirely conscious.

The pleasure of giving depends upon the scope which the donor's means allow for it, and whether the donor's ethos is of take-and-give or only of acquisition,

with no giving unless calculated for long-term gain. Giving as an instrument of social cohesion has three aspects: cohesion between givers, cohesion between giver and recipient, and cohesion through convergence on a charitable object which can be the subject of general pride.

It may be argued that the condescension of giving may not increase the bond between donor and recipient, since it draws attention to the economic and social difference between them and, especially if the condescension is explicit, can help to make the beneficiary hate the benefactor. Against this, however, must be set the social divisiveness occasioned when the rich watch the poor suffer and do nothing to help. Here we seem to have the uncertainties of giving opposite the virtual certainties of not giving.

Apart from these reasons for giving, and apart from giving out of self-interest, there are causes not otherwise accounted for but also difficult to specify. Ostentation, social advancement or the requirement of one's rank (*noblesse oblige*) may emerge from this amorphous mass of motivation, and others beside. Nevertheless, public giving may well in the end defy exhaustive causal analysis, however detached a view we may take of it as items of observable behaviour. For these reasons, if for no other, retrospective psychology is not a subject of this research. Subscriber behaviour is, however, and therefore questions of motivation can arise, but not answers.

It may also perhaps be fruitful to look at public giving anthropologically, and compare its occurrences across a range of societies, various in place and time. This is, however, a field outside the writer's competence.

6.4 `CHARITY UNIVERSAL'

It is clear from the numbers entering the Bristol Infirmary that the enterprise was not, from the Subscribers' point of

view, a mere token, expressing pride or salving the conscience. (Compare, for instance, Winchester County Hospital where until 1759 only 5 beds were open, with the 132 beds of the Bristol Infirmary available from 1755, although Bristol and environs had far fewer people than Hampshire.) As has been noted, 746 In-patients and 2060 Out-patients admitted in 1761-2 alone from City parishes represents 1.96% and 5.42% of the population respectively. If an estimate is made of the Subscribers living in or owning property in the city, the number would have amounted to about 1% of the city's population, that is, about 380 out of 38,000. If we consider those who would have known a patient or Subscriber, and perhaps also those who would have known somebody who knew one, we can see that the Infirmary must have been not some obscure enterprise but an institution looming large in the consciousness of each Bristolian. (Incidentally, since it was in the public eye to this extent and there was an unsatisfied demand for In-patient places, it may be that experience reinforced a belief that the Infirmary could benefit the patient.)

Between 1737 and 1746 successive changes in the Rules opened the Infirmary to patients irrespective of origin. In 1761-2 26.5% of In-patients and 13.6% of Out-patients came from outside the city, 13.7% and 4% respectively coming neither from the city nor adjacent parishes such as Clifton and Bedminster. There is no evidence that this universal receptivity benefitted the Subscribers, or could have been calculated to be of advantage to them. It is questionable whether the money contributed by out-of-town Subscribers balanced the cost incurred in treating those recommended by them.

The Infirmary began with the motto `Charity Universal' and has retained it. Whether changes between 1980 and 1994 have subverted this principle is not a matter for discussion in this thesis, but the Protestant business folk of 18th century Bristol are likely to have taken principles seriously, not least when they had made a public

commitment to them. The means by which we get our subsistence is powerful in conditioning the possible range of our hopes, fears, ideas and philosophy of life, but these, when hatched out of material circumstance can take on a life of their own. The historian or sociologist needs to remember that we all like life to have consistency and our own lives to have meaning, and that a principle can therefore compete with gain of wealth, especially when our material circumstances are such as to make adherence to principle affordable and only just painful enough to give a feeling of being virtuous.

6.5 POWER IN HOSPITALS : AMATEURS AND PROFESSIONALS

It may be helpful to put Subscriber power into a wider context of time. Power in hospitals has been shifting throughout European history. The mediaeval hospital was ecclesiastical, generally monastic, with gradual increase of academic influence in some places (but not in these islands). During the Renaissance, in many Continental cities, provision for the sick poor was municipal, with power in the hands of a small number of wealthy and powerful citizens. Under the Commonwealth, England had two state hospitals, an initiative aborted under Charles II. In the 18th century the new voluntary hospitals in the British Isles had different power structures. Edinburgh Infirmary from the outset had strong academic influence. Winchester County Hospital began on the initiative of an ecclesiastic, with the explicit intention of working in support of the poor law authority. The Westminster Hospital and Bristol Infirmary were citizen hospitals, run by all who were able and willing to subscribe. Within the voluntary hospitals there arose a dominance by the surgeons and physicians from the late 18th century or early 19th, as Fissell points out for Bristol. As Poor Law institutions became municipal hospitals, and as further hospitals (such as Southmead Hospital in Bristol) were added to these, there evolved hospitals in which elected power arose opposite medical power. In 1947 the municipal hospitals accounted for 70% of

the United Kingdom's hospital beds, charities accounting for nearly all the rest. In the National Health Service less accountable public bodies worked within a general framework of state provision, with continuing medical power and some public checks from outside the hospitals. In the decade up to 1994 government power has been strengthened centrally, while peripheral power, within individual hospitals or groups of them, has passed to state-appointed functionaries who represent government policy and are answerable neither to the public nor to the healing professions, so that there is consolidation of central power with decentralisation of ostensible organisation.

The purpose of offering this sequence is to emphasise that the Subscribers of Bristol Infirmary can be seen to belong to only one period, and with means and ends not used for all voluntary hospitals even within that period. The specificity of time and place is essential to any perspective on Bristol Infirmary between 1735 and, say, 1775. It may also throw into question assertions which conflate this place and period with others.

What questions are raised by Subscriber government in what has just been called a citizen hospital? First, we may ask whether this system of government was successful. In asking this we should not imagine that all Subscribers were equally active in the work of running the Infirmary. All democratic bodies have their activists and their easy-going assenters. The Champion dynasty of Treasurers in the 18th century makes the point, even if the personal responsibility of the Treasurer to meet any deficit confined the post to a rich minority. It is most unlikely that every Subscriber would or could give up the time to admit patients on Mondays and Thursdays, or to visit the wards to hear patients' complaints. Nevertheless, in the period under study, all (that is, all male) Subscribers (cf. p.71) were eligible for all tasks (bearing in mind the financial limitations just mentioned, on the choice of Treasurer) and a body can be judged not only, if at all, by

what the majority do, but also by the work of the smaller groups of activists which it throws up.

The government of the Infirmary in the mid-18th century was successful qualitatively and quantitatively. The qualitative point is made by the efficacy of the Infirmary as a place of healing, discussed above. Quantitatively, the rate of expansion is worthy of note. The bed numbers rose from 32 in 1737 to 132 in 1755 with further increases following later in the century and early on into the next.

This leads to a second question: to what can this success be attributed? An answer that might be offered by some in our own day is that the Subscribers, or male Subscribers at least, were business men, of a type similar to many of the state-appointed administrators in recent years. The similarity does not, however, stand up to close inspection. The Bristol business men were intimately involved with the goods in which they traded, or their manufacturing processes, or the everyday details of most of the enterprises which they financed. Further, many of them were in a small way of business, as small and intimate as a modern manufacturer using two or three rooms in a converted warehouse, or a modern independent shopkeeper with assistance from two members of the family. Subscribers were likely to have understood well the Infirmary's day to day problems in their human aspects as well as in their financial management. The Bristol Subscribers almost certainly had a wider variety of experience, often including manual skill, than have today's health administrators, and were less able to insulate themselves from the values of the healers and the hopes of the patients.

Nevertheless, the question opens up further matters. Consideration in further enquiries might have to be given to the relative merits of amateur enthusiasm and professional interest. It may be asked whether any essentials of the enterprise were possible only because of

the civic independence of Bristol, greater in some respects, if not all, than that of the city in the mid-20th century, and in all respects greater than the independence of any local authority in 1995. Such questions lead to a further query; what part, if any, did the mid-18th century Bristol Infirmary play in strengthening civic cohesion, and in what respects, if any, was it a product of that cohesion? The point of these speculations is to indicate that the civic context was reflected in an early voluntary hospital, with that context seen to be a complex of relations with the hospital itself as part of the web, and not simply as something affected or caused. However, any research on this will need to have specificity of time and place.

6.6 A NEW TYPOLOGY OF THE VOLUNTARY HOSPITALS

It is to be hoped that sufficient studies specific to time and place will help to classify 18th century voluntary hospitals by functional characteristics of social importance. Already in the present work distinction is adumbrated, even if still very tentatively. To show this, points made earlier can be taken up again and set side by side.

Winchester County Hospital had as one of its objects to relieve the Poor Law institutions of at least some of the burden of the sick poor. The Exeter Infirmary also accepted the chronic sick; treatment there was sufficiently uneventful for there to be no need for candles during the hours of sleep. Dr. Alured Clarke, prebendary of Winchester cathedral, who founded Winchester County Hospital, was influential in framing the rules and organisation of Exeter, where he became Dean and himself laid the foundation stone of the hospital. Bristol Infirmary, on the other hand, was founded explicitly to help the `Laborious-Industrious Poor', that is, poor earners, not the paupers who were the concern of the Poor Law, which in Bristol was manifested in the Corporation of the Poor. Correspondingly, the Bristol Infirmary was under no

obligation to accept the chronically sick, whom its Rules in fact excluded, at least in so far as Rules can make things happen when nature offers uncertainty.

Thus we seem to have two distinct lines of tradition. One kind of hospital is associated with backing up Poor Law provision and providing for the chronically sick, while the other is associated with a function distinct from, and complementary to, that of the Poor Law, and provides for the acutely sick or injured among the `Laborious-Industious Poor'. Bristol modelled itself on the Westminster Hospital, and on Bristol were Worcester Infirmary and Gloucester Infirmary modelled, with Shrewsbury Infirmary following Worcester. Winchester County Hospital was firstly the model for Exeter Infirmary with Salop Infirmary and Norwich Infirmary following soon after. These lineages do not comprehend all the 18th century voluntary hospitals. For example, Edinburgh had an academic foundation, while in London St. Bartholomew's and St. Thomas's were of mediaeval monastic origin. However, similarity of institutional type does not necessarily indicate similarity of purpose; hospital priority and policy reflected the sympathies of those who co-founded the charity and even these might change over time. The crudity of superimposing similar perspectives on highly diverse urban contexts assumes a unity of purpose and method among the voluntary movement that a close inspection of the evidence indicates is simply not merited.

To pursue this matter further requires an investigation similar to much of that reported in this thesis, but for each of a number of hospitals. Nevertheless, the work reported here, because of its specificity in time and place, has avoided smudging distinctions between the organisation and purposes of different hospitals, and so has been able to throw up an initial clue suggesting a major line of investigation hitherto (it would appear from the literature) unconsidered.

The way is now open to a typology of early voluntary hospitals.

6.7 METHOD

In Section 0.2 of the Introduction the method of this study was described. In particular, the exhaustive use of one year's statistics was proposed as a means of avoiding sampling error and conflation of periods during change. It can be seen that, in practice, this method still permits general conclusions, while putting them on a firm foundation. Within this field of research the method used here opens up new possibilities, not least because of the need for specificity of time, already noted in this chapter.

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30 C.M. MacInnes, `Bristol and the Slave Trade', in McGrath (ed.), *Bristol in the 18th century*, p.169.
31 Ibid., p.172.
32 Ingram and Anon., `Slavery',
33 MacInnes, `Bristol and the Slave Trade', in McGrath (ed.), *Bristol in the 18th century*, p.172.
34 Defoe, *A Tour through England and Wales*,, vol. 2, pp.36-7.
35 John Castelman, *A Sermon Preached before the Subscribers to the Bristol Infirmary, At their Anniversary Meeting in the Parish Church of St. James. On Tuesday, March the 13th, 1743*, London, Thomas Tyre, 1744, pp.42-3.
36 Latimer, *The Annals of Bristol*, For journeyman carpenters see p.268; itinerant preachers pp. 306-7; taylors p.315; carpenters p.372; agricultural labourers p.385.
37 John Aylmer, *The Bristol Infirmary recommended in a Sermon, Preach'd before the Subscribers, at the Parish Church of St. James, July 12, 1757*, Bristol, Cadell, 1757, p.12. The use of child labour in textiles was noted by Defoe for 1720. (Cited by Rosalind Coward, `Kids on the block', *Guardian*, 2nd December, 1994.) In Bristol this may or may not reflect a shortage of labour.
38 Latimer, *The Annals of Bristol*, p.336.
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46 Wesley, *Journal*, p.41.
47 Bettey, *Bristol Observed*, p.77.
48 P. T. Marcy, `Eighteenth Century Views of Bristol and Bristolians' in McGrath (ed.), *Bristol in the 18th century*, p.25.
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61 John Browning, `The Number of People in the City of Bristol, calculated from the Burials for Ten Years successive, and also from the Number of Houses', Phil. Trans. Roy. Soc. vol.48 Part 1, 1753, pp.217-20.
62 Sketchley, *Bristol Directory*, p.120.
63 Pugsley, `Economic Development of Bristol', p.3.
64 Browning, `Number of People in Bristol', p.220.
65 Latimer, *The Annals of Bristol*, p.194.
66 *`Bristol Infirmary Subscription Book'*, 1736-63.
67 Latimer, *The Annals of Bristol*, p.420.
68 William Matthews, *The New History*, pp.73-4.
69 Ibid., p. 75.
70 E.E.Butcher, *Bristol Corporation of the Poor 1696-1834*, Bristol, Bristol Record Society Publications, vol.3, 1932.
71 Ibid., p.10.
72 James Johnson, *Transactions of the Corporation of the Poor, in the City of Bristol, During a period of 126 years*, Bristol, P. Rose, 1826, p.75.
73 Kenneth Dewhurst, *The Quicksilver Doctor: The Life and Times of Thomas Dover, Physician and Adventurer*, Bristol, John Wright & Sons Ltd., 1957, p.2.
74 Ibid., p.1.
75 Butcher, *Corporation of the Poor*, p.11.
76 Dewhurst, *The Quicksilver Doctor*, pp.153-65. Standard treatment called for mercury compounds, more rarely the element, particularly in syphilis. This was a condition a medical practitioner in a busy sea port who was also the owner, and sometime captain of, a pirate vessel, might well have been called upon to treat.
77 Johnson, *Transactions of the Corporation*, p.112.
78 Butcher, *Corporation of the Poor*, p.12.
79 John Cary, *An account of the proceedings of the Corporation of Bristol, in execution of the Act of Parliament for the better employing and maintaining the Poor of that City*, London, F. Collins, 1700. Readers are referred to Sacks, *The Widening Gate*, pp.328-52 for a review of John Cary's views on political economy, trade and manufacture.
80 Anon., *Some considerations offer'd to the citizens of Bristol relating to the Corporation for the Poor, in the said City*, Bodleian Library, Bound with Gough Somerset 50, n.p., 1711.
81 Butcher, *Corporation of the Poor*, p.11.
82 Johnson, *Transactions of the Corporation*, p.97.
83 Ibid., p.123.
84 Fissell writes that it is probable that the trigger for the inauguration of Bristol Infirmary was the founding of Winchester Hospital. (See *Patients, Power and the Poor*, p.74.) This is true only in so far as Winchester Hospital opened up a house it already owned for the

reception of sick people in October 1736. Until 1759 the bed complement remained constant at 5 places. Referring to the jostling for first place in the field of provincial medical establishments G.M. Smith writes `...the Bristol Infirmary was ready for use before either [Winchester Hospital and Edinburgh Infirmary]; but if the hiring of a house for the use of poor patients is equivalent to founding a hospital, both these institutions have claims prior to those of Bristol. *History of the Bristol Royal Infirmary*, p.9. Richard Smith also refers to the jostling for first position. In his *Biographical Memoirs*, vol. 1, he writes, `Bristol claims the honour of having set the whole of Great Britian the example of a Provincial Infirmary supported entirely by the voluntary Contributions of her Citizens and neighbours; previous to this, nothing of the kind had been attempted out of the Metropolis as may be seen by the following sites and notations of these Charities with the Dates of their foundation; Bristol 1735, Winchester 1736, Edinburgh 1736, York 1740..' However, Richard Smith's observations may require further explanation. The question of priority is, in any case, of little importance. What matters is that Bristol explicitly took Westminster, not Winchester, as its model.

85 G.M. Smith, *History of the Bristol Royal Infirmary,* p.7.

86 Ibid., pp.7-8. See also Fissell, *Power, Patients, and the Poor,* p.75, where she attributes the idea to John Elbridge and makes no mention of Bonython anywhere in her book.

87 See, for example, *The Bristol Journal*, 15th January, 1763.

88 G.M. Smith, *History of the Bristol Royal Infirmary*, p.72.

89 Roy Porter, `The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth-Century England', in Lindsay Granshaw and Roy Porter (eds.), *The Hospital in History,* London, Routledge, 1989, p.168.

90 *Rules, 1758,* Rule XI.

91 P.S.Brown, `Medicines Advertised in Eighteenth-century Bath newspapers', in *Medical History*, vol.20, no.2, 1976, p.161.

92 See *The Bristol Journal* for 1762 & 1763 passim.

93 *Rules*, 1758, Rule XXX.

94 Ibid., Rule I.

95 Ibid., Rule II.

96 `Bristol Infirmary Minute Book', 1736-72, entry dated 23rd December, 1736.

97 *Rules, Confirm'd by the Subscribers to the Bristol Infirmary, at their several General Boards, From the first Institution of the Society in the Year 1737 to the First of January, 1743*. Bristol, S.Farley, 1743, Admission and Discharge of Patients, II.

98 *The Annual Account of the Bristol Infirmary, for the Year, ending December 21st, 1747,* Bristol, S. & F.Farley, 1747.

99 Origins here numbered 6---, that is patients defined not by their place of origin but by a personal description

such as `a sailor boy', are assumed to be `honorary' citizens of Bristol for the purpose of this study on the grounds that they were representative of the `floating' population of the city. The only exception to this rule concerning `persons' rather than `places' is in the case of the the 17-year-old male, Joachim Backer. He had two admissions and his parish is described variously as `a foreigner' and as `Hamborough'. Both admissions are given the parish location of 6205.

100 `Minute Book', 1736-72, entry dated 29th February, 1739.
101 Ibid., entry dated 7th March, 1739.
102 Fissell, *Patients, Power, and the Poor*, pp.95-7, passim.
103 This difference is not confined to Bristol but is general throughout the country. See, for instance, John Woodward, *To Do the Sick No Harm* p.150 where he quotes from `An account of the establishment of the county hospital at Winchester'. `It provides for the relief and comfort of Multitudes who are unable to be at the expence of Advice or Physick, but are not distinguished by the name of The Poor, because They do not come under the care of a Parish or a Workhouse; and yet are the principal objects of this Charity, and most of all entitled to the regards of the Public; since They are in present want; and are of the diligent and industrious, that is, of the useful and valuable part of all Society.' (`The Laborious-Industrious Poor' were those with a record of regular employment who therefore had an income when not disabled, as opposed to the `pauper' who was destitute.)
104 *Rules, 1758*, Admission and Discharge of Patients, VII.
105 Ibid., Admission and Discharge of Patients, V.
106 Richard Smith, *`Biographical Memoirs'*, Bristol, 14 vols., vol.1, p.96.
107 A.E.Clark-Kennedy, *The London* vol.1, p.60.
108 *Rules, 1758*, Admission and Discharge of Patients, V.
109 *Rules, Confirmed by the Subscribers to the Bristol Infirmary At their several General Boards From the first Institution of the Society in the Year 1737, to the 1st of January, 1779*, Bristol, Bonner and Middleton, 1779, Admission and Discharge of Patients, VI.
110 *Rules, 1758*, Admission and Discharge of Patients, V.
111 Ibid., XXV.
112 G.M. Smith, *History of the Bristol Royal Infirmary*, p.15.
113 Fissell, *Patients, Power, and the Poor*, p.88.
114 Turner, *Story of a Great Hospital*, p.96.
115 Castelman, *A Sermon*, p.35.
116 `Bristol Infirmary Legacy Book', 1736-1877.
117 *Rules, 1758*, Rule XXII.
118 Fissell, *Patients, Power, and the Poor*, p.9.
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122 *Rules, 1779*, Rule XXX.

123 *The State of the Bristol Infirmary, from December 31, 1761, to December, 31 1762, inclusive,* Bristol, S.Farley, 1763.
124 G.M. Smith, *History of the Bristol Royal Infirmary,* p.19.
125 Contained in Richard Smith's *Biographical Memoirs,* Vol.1, is a list complied by Dr. James Ford of the names of patients on which he had privately performed the operation of lithotomy. The patients' ages ranged from 5 to 68 years. There were 2 deaths amongst the 25; the rest were stated to be cured. Patients came from far afield to be treated; London, Shepton Mallet, Wells, Bideford and Carmarthen are among the addresses given. Richard Smith adds a rider to the list saying that the operations appear to have been carried out over a period of 9 years.
126 G.M. Smith, *History of the Bristol Royal Infirmary,* p.56
127 Ibid., p.56.
128 Turner, *Story of a Great Hospital*, p.17.
129 G.M. Smith, *History of the Bristol Royal Infirmary,* p.380.
130 *Rules, 1758*, Physicians and Surgeons, V.
131 One of the two other patients was the only one out of 26 patients for whom In-patient admission for the treatment of tinea, a not very serious skin condition, had been granted. The other patient was found not to be suffering from dropsy as at first supposed, but to be pregnant, - not a condition necessarily requiring medical intervention.
132 An over-time patient was one who had been warded for more than 13 weeks. No patient was allowed to remain longer than this unless the Trustees had given special permission, this permission having been sought by the physician or surgeon who admitted the patient on the grounds that a longer stay was necessary in order to effect a cure. See Rules, 1758, Rule XXII.
133 Fissell, `The "Sick and Drooping Poor"' p.51. Fissell's data are derived from the Bristol Infirmary admisssion books for 1771-1805 and linked with the parish register of Sts. Philip and Jacob.
134 Ibid. p.52.
135 Index no. 0995M.
136 Index no. 0427F.
137 Index nos. 0339F, 0542F, 0411F.
138 *Rules, 1758*, House Visitors, Rule 1. Infirmary Rules required that all Subscribers should take their turn as House Visitors. Such a system ensured that interest did not wane and oversight and administration remained firmly in the hands of lay men (but women subscribers are not found among the Visitors). The House Visitors were not afraid to confront the medical staff and, for instance, more than once expostulated with the surgeon, William Thornhill, over his irregularity in visiting the Infirmary. See G.M. Smith, *History of the Bristol Royal Infirmary*, p.70.
139 John Langdon-Davies, *Westminster Hospital,* p.62.
140 Ibid., p.64.

141 George Bernard Shaw, *The Doctor's Dilemma*, Harmondsworth, Penguin, 1987
142 `Legacy Book', 1736-1877.
143 *Rules, 1758*, Admission and Discharge of Patients, III.
144 Fissell, *Patients, Power, and the Poor*, p.11, states that it did.
145 Ibid., p.12.
146 Sidney and Beatrice Webb, *English Local Government, English Poor Law History*, Part 1, The Old Poor Law, London, Longmans, Green & Co., 1927, p.371 tells of one who got away!. `At Bristol, in the latter part of the 18th century, we frequently find references to the sympathy of the mob for the vagrants whom the constables had to apprehend, and the difficulties caused thereby. In 1786 an officer sought to arrest a woman, who was shamming illness in a churchyard for the purpose of extracting money from passers-by. On the officer attempting to take her to St. Peter's Hospital, she threw herself down on the street, and attracted a crowd of persons who so seriously attacked the constable that he had to flee for his life.'
147 Ibid., p.12.
148 Tucker, *A Sermon*, pp.3-4.

REFERENCES TO CHAPTER TWO

1 *Rules*, 1779, Rule XXXIII.
2 *Rules*, 1758, House Visitors, 1.
3 Obviously, subscribing to the Bristol Infirmary was an activity in which women could participate. Whether they did so as a means of assisting or supporting their husbands in the husbands' activiies, in the sharing of a common interest, or as an independant act, that is to say on their own initiative, is uncertain. The last is sometimes very probable.
4 Amongst these sources are *The Bristol Poll Book*, April 1754, Bristol, E. Farley; Sketchley, *Bristol Directory*; A.B.Beaven (ed.), *Bristol Lists, Municipal and Miscellaneous*, Bristol, T.D. Taylor, Sons, and Hawkins, 1899; `Society of Friends Subscription List, 1763', B.R.O. Ref. SF/F/2; `Lewins Mead Records: Annual Collections 1755-1759', Reference 6687 (4). Apppendix 5 of this thesis sets out all the relevant data concerning the Subscribers on which this work is based.
5 Roy Porter, `The Gift Relation', p.159.
6 David Owen, *English Philanthropy 1660-1960*, Cambridge, Mass. Harvard University Press, 1964, p.13.
7 Abraham Elton, Baronet; the Bishop of Bristol, Lord Seker and his succesor, Bishop Thomas.
8 John Woodward, *To Do the Sick No Harm*, p.17.
9 *Rules, 1758*, Rules, I & II; Admission and Discharge of Patients, III.
10 Roy Porter, `The Gift Relation', p.157.
11 Anon., *Animadvertory Letter In Answer to the Tract and Supplement That were published by Mr. Edward G--L--K,*

And Addressed to the Subscribers of The Bristol Infirmary, Bristol, S. Farley, 1765, passim.
12 Index no. BR4.
13 Index no. LL2.
14 There are minor discrepancies between the manuscript and printed subcription lists, and the quoted number of Subscribers as recorded in the text of the States is marginally different from the number of names actually listed for both 1761 and 1762. The discrepancies may be due to differences in the exact dates to which counts refer.
15 140 In-patients were admitted as Casualties. This number has therefore been deducted from the total of In-patients admitted in order to arrive at this percentage.
16 Index no. TU3.
17 Index no. DU4.
18 Index no. CH1.
19 Index no. BU1.
20 Index no. BU2.
21 G.M. Smith, *History of the Bristol Royal Infirmary*, p.61.
22 John Browning, `Number of People in Bristol', vol.48 Part 1, 1753, p.219.
23 Index no. BA8.
24 William Barnes, Snr. admitted no patients in the twelve months under review and therefore has not been allocated an Index no.
25 William C. Braithwaite, *The Second Period of Quakerism*, London, Macmillan & Co. Ltd., 1919, pp.566-7.
26 `Legacy Book', 1736-1877.
27 Edward Garlick, *Tract To The Subscribers of the Bristol Infirmary* and *A Supplement to an Address to the Subscribers of the Bristol Infirmary, by a Subscriber*, n.p., c.1764.
28 Index no. SM2.
29 Robert Nugent admitted no patients in the twelve months under review and therefore has not been allocated an Index no.
30 Beaven, *Bristol Lists*, passim.
31 Sir Onesiphorus Paul admitted no patients in the twelve months under review and therefore has not been allocated an Index no.
32 Index no. EL6.
33 Index no. KE2.
34 Index no. SM2.
35 Norbourne Berkeley admitted no patients in the twelve months under review and therefore has not been allocated an Index no.
36 `Minute Book', 1736-72, entry dated 6th January, 1737.
37 Index no. BE7.
38 Index no. BE6.
39 Capel Hanbury admitted no patients in the twelve months under reveiw and has therefore not been allocated an Index no.
40 Index no. SA1.
41 Index no. SA3.
42 `Minute Book,' 1736-72, entry dated 5th March, 1744.
43 *Rules*, 1758, Rule XXIV.

44 James Johnson, *Transactions of the Corporation,* p.48.
45 Fissell, `The "Sick and Drooping Poor"', p.37.
46 James Johnson, *Transactions of the Corporation,* p.48.
47 G.M. Smith, *History of the Bristol Royal Infirmary,* p.37.
William Williams has been allocated the Index no. WI5.
48 Jonathan Barry, `Piety and the Patient', p.173.
49 Index no. ST3.
50 Index no. LI1.
51 Index no. BA5.
52 Index no. LE2.
53 Index no. PE5.
54 Ronald Mayo, *The Huguenots in Bristol*, Bristol branch of the Historical Association, Bristol, 1985, p.22.
55 For a discussion on the motivations of benefactors see Sandra Cavallo, `Motivations of benefactors'.
56 Index no. HO7.
57 Index no. CL1.
58 Index no. 0989F.
59 Index no. 1697M.
60 Index no. 3132M.
61 Index no. 0904M.
62 Index no. GO1.
63 Thomas Beddoes, *Hygeia: or essays moral and medical on the causes affecting the personal state of our middling and affluent classes*, 3 vols., Bristol, J. Mills, 1802, vol.1.
64 John Wesley, *Primitive Physik*, London, Printed and sold by Thomas Tyre, 1747.
65 *Rules,* 1758, Admission and Discharge of Patients V.
66 Index no. PA1.
67 G.M. Smith, *History of the Bristol Royal Infirmary,* p.64.
68 Ibid., p.65.
69 Index no. LI1.
70 G.M. Smith, *History of the Bristol Royal Infirmary,* p.282.
71 Ibid., p.144.
72 Ibid., p.25. Upon being invited in 1773 to give the Anniversary Sermon the Rev. Sir John Stonehouse replied in his acceptance letter; `I must own that I have thought it rather extraordinary that I should never have been apply'd to on this occasion by the Governors during my ten years residence here and could consider it no other point of view than as a personal Disrespect'. There is no evidence that he did ever preach the Sermon! It is a tight network that binds patients, Subscribers and medical practitioners together, and this personal detail is offered to make the point.
73 Index no. TU3.
74 Nikolaus Pevsner, *The Buildings of England,* p.411.
75 Ibid., p.365.
76 G.M. Smith, *History of the Bristol Royal Infirmary,* p.59.
77 The wall plaque in St. Mary Redcliffe Church, dedicated to the memory of Mrs. Fortune Little, is but one example, while the large, ornate and coronetted table top tomb of Onesiphorous Paul which dominates the

graveyard at Woodchester Priory, near Stroud, Gloucestershire is another.

78 Richard Champion II (Index no. CH1) was a member of the Quaker dynasty of Infirmary treasurers. His term of office extended from 1753 to 1766. See G.M. Smith, *History of the Bristol Royal Infirmary*, p.481.

79 Ibid., pp.100-5.

80 Ibid., p.101.

81 *Rules*, 1758, Rule VIII.

82 G.M. Smith, *History of the Bristol Royal Infirmary*, p.57.

83 Ibid., p.43.

84 Ibid., p.61.

85 *An Account of the Bristol Infirmary, From the first Institution to this Time, n.p., n.d.*, Rule II. Life membership rate was raised to 30 guineas in the 1758 Rule Book.

86 Ibid., Matron II.

87 G.M. Smith, *History of the Bristol Royal Infirmary*, p.29.

88 Anon., *Animadvertory Letter*, p.51.

89 Ibid., pp.33-4.

90 Referring to Northampton Infirmary, Roy Porter reports that the average cost of an In-patient amounted to about £3 12s 0d. See `The gift relation' p.163. Figures prepared by the Department of Health and published in an article, `Week in NHS hospital costs over £1,000', by David Brindle in *Guardian* 7th August, 1993 show that the average cost of caring for an In-patient for a week in 1992 was an estimated £1,072 with pharmaceutical services accounting for 10.3% of the cost.

91 *Pharmacopoeia in usum Nosocomii Bristoliensis*, Bristol, Bonner and Middleton, 1777.

92 *Rules*, 1779, Rule XXXVII. Although this Rule is dated 1779, and therefore is later than the period under discussion, the Rule was probably in force well before 1779.

93 G.M. Smith, *History of the Bristol Royal Infirmary*, p.199.

94 Ibid., p.423.

95 `An Inventory of Household Goods at the Bristol Infirmary Nehe. Champion, Treasurer under the care of Ann Hughes Matron, taken the 29 November 1751', Bristol Record Office, Reference 35893/22 (a).

96 Anon., *Animadvertoy Letter*, pp.25-6. These Infirmaries were Bristol Infirmary, Salop Infirmary, St. George's Hospital, Northampton Hospital, Gloucester Infirmary, Worcester Infirmary and Exeter Hospital.

97 G.M. Smith, *History of the Bristol Royal Infirmary*, p.22.

98 Ibid., p.91.

99 State, 1761.

100 *Rules, 1758*, Rule XXIII.

101 G.M. Smith, *History of the Bristol Royal Infirmary*, p.40.

102 Anon., *Animadvertory Letter*, p.17.

103 H. Farley, *An Account of the Hospitals, Alms-Houses, and Public Schools, in Bristol*, Bristol, H. Farley, 1775, p.26.
104 A similar view is taken by Barry. See The Cultural Life of Bristol.
105 G.M. Smith *History of the Bristol Royal Infirmary*, p.24.
106 *Rules*, 1758, House Visitors II.
107 G.M. Smith *History of the Bristol Royal Infirmary*, p.6 note 1.

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2 David Owen, *English Philanthropy*, p.2.
3 H. Farley, *An Account of the Hospitals*, p.8.
4 Castelman, *A Sermon*, p.25.
5 On atttudes to work and idleness, see R.H. Tawney, *Religion and the Rise of Capitalism: a Historical Study*, London, John Murray, 1926.
6 James Johnson, *Transactions of the Corporation*, p.34.
7 Rotha Mary Clay, *The Mediaeval hospitals of England*, London, Methuen, 1909, pp.88-9.
8 G.M. Smith, *History of the Bristol Royal Infirmary*, p.15.
9 Elbridge set up his charity school for the education of twentyfour girls, eight from each of the three parishes of St. Michael's, St Peter's and Westbury-on- Trym in the grounds of his own mansion at St. Michael's Hill, in the year 1737. See also H. Farley, *An Account of the Hospitals*, p.20.
10 W.S. Lewis and R.M. Williams, *Private Charity*, p.1.
11 John Bellers, George Clarke (ed.), *John Bellers: His Life, Times and Writings*, London, Routledge & Kegan Paul, 1987, pp.179-80.
12 William Booth, *In Darkest England, and the Way Out*, London, McCorquodale, 1890, p.17.
13 In 1688 Gregory King reckoned that over one million persons, nearly a fifth of the whole nation, were in occasional receipt of alms, mostly in the form of parish relief. See George Trevelyan, *English Social History*, p.242.
14 Owen, *English Philanthropy*, p.39.
15 Richard Titmuss, *The Gift Relationship: from Human Blood to Social Policy*, London, George Allen & Unwin Ltd., 1970, Ch.2, The Transfusion of Blood.
16 A.Delbert Evans and L.G. Redmond Howard, *The Romance of the British Voluntary Hospital Movement*, London, Hutchinson & Co. (Publishers) Ltd., n.d., p.135.
17 Lewis and Williams, *Private Charity*, pp.7-11.
18 Ibid., p.9. (Cited from an undated letter published in the Literary Magazine.)
19 Richard Collier, *The General Next to God*, Glasgow, Fontana/Collins, 1977, p.49.

20 John Woodward, *To Do the Sick No Harm,* Appendix 2, `An Account of the Establishment Of the County-Hospital at Winchester.
21 *Rules,* 1758, In-Patients, VIII.
22 Porter, `The Gift Relation', p.149.
23 Alexander Pope, John Butt (ed.), *The Poems of Alexander Pope: A one-volume edition of the Twickenham text with selected annotations,* London, Methuen & Co. Ltd., 1984; An Essay on Man, Epistle iii, lines 307-8, p.535.
24 Sandra Cavallo, `Motivations of Benefactors', p.52.
25 Ibid., p.53. On Cavallo's last point, see Cole, `Various Parochial Antiquities', on the fear that founding the Bristol Corporation of the Poor would open civic government to dissenters.
26 Roy Porter, `The Gift Relation', p.151-2.
27 Donna Andrew, in referring to charity sermons, makes the point that `These sermons were attempts to convince their audiences of the efficacy of their particular charity and of its national, social or policy value. Thus the charity sermons speak to us in voices louder than their own, for in many ways they articulate the hopes and motives of their audiences whose opinions are otherwise almost entirely unknown and unrecorded.' `Two medical Charities', pp.82-96.
28 G.M. Smith, *History of the Bristol Royal Infirmary,* p.25.
29 George Shelton, *Dean Tucker and Eighteenth-Century Economic and Political Thought,* London, Macmillan, 1981, p.39.
30 Broughton, *A Sermon,* Title page.
31 I have difficulty in tracing the source for this quotation, having noted it and lost the reference.
32 Broughton, *A Sermon,* p.17.
33 Tucker, *A Sermon,* p.3.
34 Aylmer, *A Sermon, p.16.*
35 Castelman, *A Sermon,* p.10.
36 Ibid., p.43.
37 John Bellers, *His Life,* pp.179-80
38 Carew Reynell, *To John Elbridge, Esq; Treasurer; [a sermon preached on December 12th, 1738 at the Parish Church of St. James] by whose Great Benefactions the Bristol Infirmary Has been hitherto chiefly supported; And to the rest of the Worthy Contributors to this Truly Christian Design.* n.p., n.d., pp.11-12.
39 Thomas Johnes, *A Sermon Preached Before The Trustees of the Bristol Infirmary, at their Anniversary Meeting, in the Parish Church of St.James in Bristol, September 10, 1778,* Bristol, Bonner and Middleton, 1779, p.7,
40 Reynell, *A Sermon,* p.16.
41 Ibid., p.16.
42 Castelman, *A Sermon,* p.37.
43 Ibid., p.43.
44 Aylmer, *A Sermon,* p.11.
45 Castelman, *A Sermon,* p.25.
46 Ibid., p.40.
47 Broughton, *A Sermon,* p.16, `What greater Act of Kindness is there within the reach of *Friendship,* than to remove the complicated Distress of *Sickness* and *Poverty* united?

Sore Evils both, but much sorer in Conjuction with each other! Medicine cannot be provided without Money, nor Industry followed without Health. Thus the wretched Sufferer is cut off from the necessary Means both of his Cure and his Livlihood; while (O Circumstance of extreme Distress!) his Poverty is increased by the Continuance of his Sickness, and his Sickness grows every Day severer by the Increase of his Poverty.'

48 Johnes, *A Sermon*, p.12, `These complicated cases of sickness and poverty form a most grievous distress. These evils much heighten and aggravate each other.'

49 Castelman, *A Sermon*, p.43.

50 Ibid., p.44.

51 Ibid., p.44.

52 Ibid., p.44.

53 John Camplin, *A Sermon Preached in the Parish Church of St.James, Bristol, before the Subscribers to the Bristol Infirmary, At their Anniversary Meeting, on Wednesday, July 9, 1766*, Bristol, S. Farley, n.d., pp.9-10.

54 Castelman, *A Sermon*, p.46.

55 *Bible*, Authorised Version, Luke 16:9.

56 Joseph A Fitzmyer, `The Gospel according to St. Luke X-XXIV', *The Anchor Bible*, vol.28A, Garden City, New York, Doubleday & Co. Ltd., 1985, p.1107.

57 Castelman, *A Sermon,* p.10.

58 Johnes, *A Sermon,* pp.6-7.

59 Broughton, *A Sermon,* p.19.

60 Castelman, *A Sermon*, p.5, `Beneficence to others, is really but Kindness to ourselves; all our good Deeds return, with vast Increase, into our own Bosom: Our Neighbour, tho' rais'd by our good Offices from the Bed of Languishing and Poverty, will be profited nothing, in Comparision of the Benefit redounding to ourselves-- his *the Mammon of Unrighteousness*, ours the *true Riches*; by restoring him to this fleeting Breath *and Houses made with Hands, we make to ourselves Friends, that may receive us into everlasting Habitations.--so much more blessed is it to give, than to receive.*'

61 Samuel Seyer, *A Sermon Preach'd before the Subscribers to the Bristol Infirmary, in the Parish Church of St. James, June 17*, 1755, Bristol, T. Cadell, 1755, p.12.

62 Johnes, *A Sermon,* pp.13-14.

63 Reynell, *A Sermon,* p.13.

64 Ibid., p.8.

65 Ibid., pp.5-6.

66 Castelman, *A Sermon*, p.13, `Have we not all one Father? hath not one God created us? is not Man a social Creature? have we not all the same Passions and Affections? have we not Abilities to be helpful to each other-- and Wants that call for mutual Intercourse? nay, Wants of such a Nature, that without such mutual Assistance, the Rich would be at least as distressed, without the Help of the Poor, as the Poor without the Rich.'

67 Seyer, *A Sermon,* p.8.

68 Aylmer, *A Sermon,* p.6.

69 Camplin, *A Sermon*, pp. 10-11.

70 Reynell, *A Sermon,* p.13.

71 Camplin, *A Sermon*, p.9.
72 Reynell, *A Sermon*, p.12.
73 Camplin, *A Sermon*, pp.11-12.
74 It is of interest that Marx considers that only in liberal political economy, the most advanced stage of economic theory before him, is labour seen to be the source of profit. Istvan Meszaros, *Marx's Theory of Alienation*, London, Merlin Press, 1986, pp.140-6.
75 Camplin, *A Sermon*, p.12.
76 Tucker, *A Sermon*, pp.8-9.
77 Ibid., p.5.
78 Ibid., p.10. The Corporation of the Poor taught skills, and these could have led, through apprenticeship, to craft status, and so to the freedom of the city, all in one life-time.
79 Ibid., p.9.
80 Ibid., p.10.
81 Ibid., p.11.
82 G.M. Smith, *History of the Bristol Royal Infirmary*, p.26.
83 Fissell, *Patients, Power, and the Poor*, pp.84-5.
84 Aylmer, *A Sermon*, p.16.
85 Fissell, *Patients, Power, and the Poor*, pp.84-5.
86 Castelman, *A Sermon*, p.26.
87 Seyer, *A Sermon*, pp.13-14.
88 Reynell, *A Sermon*, p.14.
89 Ibid., p.14.
90 Aylmer, *A Sermon*, pp.12-13.
91 Broughton, *A Sermon*, p.18.
92 See also Karl Marx, *Value, Price and Profit: Addressed to Working Men*, London, George Allen & Unwin Ltd., 1938, p.62 for a later exposition of this same theme.
93 G.M. Smith, *History of the Bristol Royal Infirmary*, p.483.
94 Anon., *Animadvertory Letter*, pp.55-6.
95 *Rules*, 1758 and 1779, Matron. Note the injuction in the 1779 printing that `she particularly attend to the Ventilation of the Wards, and suffer no Wearing-Apparel to be hung upon the Bed-Rods'.
96 `Inventory', 1751. This Inventory is the nearest in time before the period under discussion available, but before the bed increase in 1755 which raised the bed-numbers to 132.
97 Fissell, *Patients, Power, and the Poor*, p.83. Fissell states `There were sometimes Bibles or prayerbooks on the wards, but not in multiple copies...'. She cites no source, and the Inventory for 1751 contradicts this.
98 Anon., *Animadvertory Letter*, pp.12-13.
99 G.M. Smith, *History of the Bristol Royal Infirary*, p.28.
100 *An Account .....this Time*, Rules, 1739, In-Patients V.
101 G.M. Smith, *History of the Bristol Royal Infirmary*, p.28.
102 Ibid., p.29.
103 Ibid., p.56.
104 Ibid., p.28.
105 Anon., *Animadvertory Letter*, pp.51-2.
106 `An Inventory of the Household Goods at the Bristol Infirmary (John Elbridge, Treasurer) under the care of

Ann Hughes Matron, taken the 9th February 1737', Bristol Record Office, Reference 35893/22 (a).

107 Anon., *Animadvertory Letter*, p.13.

108 G.M. Smith, *History of the Bristol Royal Infirmary*, p.28.

109 Anon., *Animadvertory Letter*, pp.14-15.

110 G.M. Smith, *History of the Bristol Royal Infirmary*, p.28.

111 Fissell, *Patients, Power, and the Poor*, p.67. Fissell writes that `The same kinds of nursing care were provided by the Poor Law authorities and by the Infirmary in Bristol. The Corporation of the Poor, for example, hired various women to delouse workhouse inmates. The Bristol Infirmary paid both regular full-time nurses and occasional nurses who looked after individual patients. For instance, a woman who had had a breast removed in hospital had a special nurse for a month'. Since the Poor Law had sick people in its care, nursing care is hardly surprising. The point is that we do not know that the Poor Law's standards were bad (or good), so that the comparison means little. In any case a different standard of care is required from someone employed as a de-louser than from someone employed to care for a patient following major surgery.

112 Anon., *Animadvertory Letter*, pp.33-4.

113 G.M. Smith, *History of the Bristol Royal Infirmary*, pp.21-2.

114 Ibid., p.21.

115 Anon., *Animadvertory Letter*, pp.29-31. It is recorded in the Minutes for 6th March, 1764 that savings had been made in the provision of bread, beer and cheese with no untoward effects upon the patients.

116 *Rules, 1758*, Rule XV.

117 G.M. Smith, *History of the Bristol Royal Infirmary*, p.29.

118 J.C.Drummond and Anne Wilbraham, *The Englishman's Food: A History of Five Centuries of English Diet*, London, Jonathan Cape, 1940, pp.561-5.

119 K. Diem & C. Lentner (eds.), *Documenta Geigy: Scientific Tables*, 7th. edn., Basle, J.R.Geigy S.A, 1970, pp.493-7.

120 Ibid., p.67.

121 See, for instance, Butcher, *Bristol Corporation of the Poor*, which indicates a policy that provided rather than punished.

122 *Rules*, 1779, Nurses and Servants 1.

123 G.M. Smith, *History of the Bristol Royal Infirmary*, p.29. This is Munro Smith's interpretation of the reason why the wards were cleared of nurses and servants. It could equally be that the House Visitors did not wish their tour of inspection to be observed by the minions. Even today some hospital consultants expect the ward to be cleared of `nurses and servants' while a ward round is in progress.

REFERENCES TO CHAPTER FOUR

1 Of the 4,866 houses rated to the land-tax at Michaelmas 1751, 1,018 were sited in the paish of St. James. Browning, `Number of People in Bristol', pp.219-20.
2 Index no. 0777M.
3 Index no. 0322M.
4 Robert Morris, James Kendrick and Others, s.v. `White swelling' in *Edinburgh Medical and Physical Dictionary*, 2 vols., Edinburgh, Printed for Bell and Bradfute, and Mundell, Doig & Stevenson, 1807, `The true nature of this formidable and much too common complaint is as little understood, and the cure of it so difficult, as that of any other disorder to which the body is liable'.
5 Bristol was not the only Infirmary to offer unlimited geographical coverage. See, for instance, `The State of the Gloucester Infirmary, for the Year 1764,' Gloucester, Printed by R. Raikes, n.d., and Turner, *Story of A Great Hospital,* p.52.
6 No parish is given in the Register for 2 Out-patient admissions.
7 Tucker, *A Sermon,* p.26. This is the same Josiah Tucker whose castigation of the poor and feckless has been discussed in Chapter 3 with reference to Fissell's remarks on Bristol Infirmary as a place of moral reform.
8 Index no. 0890F.
9 Index no. 0572M.
10 Index no. 0969M.
11 Index no. 0259M.
12 Index no. 0446M.
13 Index no. 0533M.
14 Index no. 0968M.
15 Index no. 0634M.
16 Index no. 0519M.
17 Index no. 1550F.
18 `Minute Book', 1736-72. Entry dated 18th February, 1736, Accepted Proposal XV.
19 Reynell, *A Sermon,* p.13.
20 Castelman, *A Sermon*, p.28.
21 L.S. Loudon, `Leg ulcers in the 18th and early 19th centuries', *Journal of the Royal College of General Practitioners,* no.31, 1981, pp.263-272. Loudon has pointed out that leg ulcers were commoner in the 18th and early 19th centuries than today, and then more usually occurred in the young and middle-aged, especially men. He notes that 49% of Bristol Infirmary cases (1785) were under the age of 30 years as were 43% of Exeter Infirmary cases (1790) and 42% of Nottingham General Hospital (1807-11) cases. In the 210 cases noted here there are 115 men; their mean age is 41 years and their median age 40, and 73 are under 46 years of age. The 95 women have a mean age of 36 years, a median age of 32, while 70 of the women are below 46 years of age. The overall picture of leg ulceration seen so frequently at Bristol Infirmary in 1761-2 differs from today's in the manner that Loudon indicates. The aetiology is not sufficiently clear-cut for it to be possible to speculate on the reason for this age difference.

22 Fissell, `The "Sick & Drooping poor"', p.51.
23 Thomas Baynton, *Descriptive accounts of a new method of treating Old ulcers of the legs*, Bristol, Biggs, 1797. Thomas Baynton commenced an Apothecary apprenticeship at the Bristol Infirmary in 1775, aged 14 years and became a successful surgeon practising in the city during the later half of the 18th century and the first half of the 19th.
24 Fissell, `The "Sick & Drooping poor"', p.49.
25 R. Morton, *Phthisiologia; or, a Treatise of Consumptions. Wherein the Difference, Nature, Causes, Signs, and Cure of all sorts of Consumptions are Explained*. London, Printed for Sam. Smith and Benj. Walford, 1694.
26 The word `phthisis' had, in the 18th century, a tendency to be used specifically for the naming of pulmonary consumption, now called tuberculosis of the lungs. Johnson's Dictionary (1760 edition), however, makes no mention of either chest or lungs in defining `consumption' or `phthisis'.
27 The four causes of asthma commonly recognised to-day are lung infection, allergy, irritants and psychological reasons.
28 *The Bristol Journal*, 15th January, 1763, p.8. Also see Brown, `Medicines Advertised', p.158 where Brown states that from a sample of Bath newspapers published between 1744 and the end of the century, 7 different medicines were advertised which purported to cure calculi of the renal tract.
29 When Charles I sold monopolies, the London soap-makers were privileged, but the Bristol soap-makers were excluded, causing anger in Bristol.
30 Leucorrhoea is characterised by an abnormal mucoid or muco-purulent discharge from the vagina, now known to be caused by a protozoal or yeast infection.
31 *Rules, 1779*, Admission and Discharge of Patients V.
32 Index no. 0075F.
33 The last verse is:

Now here's to the girl with the dark curly locks,
And here's to the girl who got Jack on the rocks,
And here's to the doctor who eased all his pain,
For he's squared his main yards, and he's cruising again.

34 Roy Porter, *English Society*, p. 234.
35 Charles Webster, `The Crisis of the Hospitals'.

REFERENCES TO CHAPTER FIVE

1 Home Office, *Protect and Survive*, H.M.S.O., 1980.
2 The writer has traced no printed Pharmacopoeia earlier than 1777. The practice of keeping two lists of the most useful prescriptions is noted by Rule XXXVIII of the 1779 Rule Book. (The copy of the Pharmacopoeia used in this work, with its MS additions, may be from one of these lists.)

3 Fissell, *Patients, Power, and the Poor,* p.9.
4 Anon., *Some considerations,* pp.12-13.
5 Broughton, *A Sermon,* p.16.
6 Buer, *Health, Wealth, and Population,* p.126.
7 Thomas McKeown and R.G. Brown, `Medical Evidence Related to English Population Changes in the Eighteenth Century', *Population Studies,* no.9, 1955, p.125. McKeown's thesis that the medical establishment played only a minor role in the demography of the period has been challenged by Simon Szreter in `The Importance of Social Intervention in Britain's Mortality Decline: c.1850-1914: a Re-interpretation of the Role of Public Health', The Journal of the Society for the Social History of Medicine, vol.1, no.1, 1988, pp.1-37.
8 Webster, `The Crisis of the Hospitals', p.215. In this quotation the `modest number' appears to refer both to the small number of patients who actually got to hospital and the proportion of Infirmary patients who were relieved.
9 Cherry, `The Role of a Provincial Hospital', p.292.
10 Ibid., p.298.
11 Woodward, *To Do the Sick No Harm,* p.142.
12 Ibid., Chapter 10, Gateways to Death? pp.123-42.
13 Index nos. 0057F, 0350M, 0395M and 0765F.
14 The omentum is a fold of peritoneum that hangs from the stomach and transverse colon and covers the underlying organs like an apron.
15 Index no. 0765F.
16 Index no. 0387M.
17 Index no. 0036F.
18 Index no. 0156M.
19 Index no. 0293F.
20 Index nos. 0650F and 0303F.
21 Index no. 0259M.
22 Inferences as to whether an infection could have been acquired in the hospital depend upon the known range of lengths of incubation periods, periods of clinical manifestation and times during the disease when death intervenes. (See Fig. 5.1).
23 Index no. 0455F.
24 Index no. 0446M.
25 Index no. 0210M.
26 Index no. 0310M.
27 Sufferers from `Smallpox, Itch or any other Infectious Distemper' were debarred from entering the Bristol Infirmary. See, for example, the 1758 printing of the Rule Book, Admission and Discharge of Patients V.
28 *Rules,* 1779, Admission and Discharge of Patients VI states; `That all In-Patients who are attacked in the Infirmary with the Small-pox, be instantly removed from it, to proper Lodgings provided by the Matron, and that their respective Physicians, and in their Absence, some other Physician belonging to the House, visit and take Care of them, and that all such Patients be supported during such illness at the Expence of the Society.'
29 G.M. Smith, *History of the Bristol Royal Infirmary,* p.113.
30 Index nos. 0059F, 0261F and 0300M amongst others.

31 Index nos. 0428M and 0541M.
32 Index nos. 0094M and 0119M.
33 Index nos. 0088M and 0765F.
34 Index no. 0323F.
35 Fissell, *Patients, Power, and the Poor*, p.108.
36 Ignaz Semmelweis, *Ignaz Semmelweis: The Etiology, Concept, and Prophylaxis of Childbed Fever*, Translated and Edited with an Introduction by K. Cadell Carter, Winconsin, The University of Winconsin Press, 1983, p.64.
37 Index no. 0164F.
38 Index no. 0106M.
39 Index nos. 0145F and 0195M.
40 Index nos. 0492M and 0929F.
41 G.M. Smith, *History of the Bristol Royal Infirmary*, pp.1-4.
42 Ibid., p.54. Bleeding was a form of depletion (`*kenosis*' or `evacuation' in Galenic medicine) originally intended to correct the balance of the humours, but still used after Galenism, as a system, had been abandoned.
43 Ibid., p.55. `In the early part of the nineteenth century it was the custom for the Out-patients who required "blooding" to sit in a row on a bench, in a room floored with a red carpet. The Apothecary, or more usually a student, tied the bandages round their arms, and then began at one end of the row and with his lancet opened a vein in each, one after the other. When the vein was opened a basin was given to the patient, who caught his own blood in it. By the time the student had reached the last on the bench No. 1 was ready to have his arm bandaged up.'
44 Ibid., p.55.
45 See Appendix 1.
46 *Rules*, 1779, Rule XXXVIII
47 Thomas Sydenham, *The Works of Thomas Sydenahm, M.D.*, Translated from the Latin edition of Dr. Greenhill by R.G. Latham, 2 vols., London, Printed for the Sydenham Society, 1848, vol.1.
48 Richard Mead, *The medical works of Richard Mead M.D.*, Edinburgh, Alexander Donaldson and Charles Elliot, 1775. Facsimile reprint of 1775 edition, New York, A.M.S. Press, 1978.
49 Nicholas Culpeper, *Culpeper's Complete systematic Herbal, and English Physician*, Manchester, J. Gleave & Son, 1826. Facsimile of 1826 edn., Hong Kong, Gareth Powell Ltd., 1979.
50 M. Grieve, *A Modern Herbal*, C.F. Leyel (ed.), Adelaide, Savvas Publishing, 1984. (This encyclopaedic work, though called `modern', covers the older as well as the current uses of plants of many lands.)
51 Sydenham, *The Works*, Vol.1, Materia Medica and Preparations, pp.cv & cvi.
52 Surgical removal of a circular piece of skull.
53 Index no. 0352F.
54 Baynton, *Old ulcers of the legs*, Bristol, Biggs, 1797, p.iv and p.115.
55 Morris, *Dictionary*. Part of the article `Ulcer' reads, Some ulcers become more difficult of cure in consequence

of their unfavourable situation. This is peculiarly the case with *ulcers of the legs*, which, till the method of treatment discovered by Mr. Baynton, of Bristol, which we shall now describe, was a most frequent affliction to the labouring classes of the community, a nuisance to the public hospitals, and an opprobrium to surgery. `Mr. Banyton's method of cure, which every day's experience tends to confirm the propriety of, consists in *bringing the edges of old ulcers gradually together by the mechanical operation of strips of adhesive plaster.* By this mode of treatment, Mr. Baynton found that the discharge was lessened, the offensive smell removed, and the pain abated in a very short time. But, besides these advantages, he also found, that the callous edges were in few days level with the surface of the sore; that the growth of fungus was prevented, and the necessity of applying painful escharotics [caustic substances] much lessened, if not wholly done away with.'

56 Mead, *Medical Works,* p.358.

57 Anon., s.v. `Typhus', in *The Compact Edition of the Oxford English Dictionary*, Oxford, Clarendon Press, 1971.

58 William Cullen, [translated from the Latin of] *Nosology: or a Systematic Arrangement of Diseases, by Classes, Orders, Genera, and Species,* Edinburgh, Bell & Bradfute, 1810. [*Synopsis Nosologiae Methodicae*, 1772]

59 Arthur Shadwell & Harriet L. Hennessey, s.v. `Malaria', in *Ency. Brit., 11th edn.*.

60 Sydenham, *The Works,* vol.2, pp.12-15.

61 Mead, *Medical Works*, p.351.

62 Sydenham, *The Works*, Vol.2. pp.31-50.

63 Mead, *Medical Works*, pp.432-3.

64 John Hunter, *A Treatise on the Venereal Disease*, London, 1786.

65 *Rules*, 1758, Admission and Discharge of Patients V.

66 Ibid., Out-Patients I states, `That the Out-Patients attend exactly at the Time appointed by the Physicians and Surgeons, and that if they absent themselves twice together without reasonable Cause, to be allowed of by their respective Physician or Surgeon, they shall be discharged for Non-Attendance.'

67 Edmund Owen, s.v. `Venereal diseases', *Encyc. Brit.*, 11th edn..

REFERENCES TO CHAPTER SIX

1 Foucault, *The Birth of the Clinic.*

2 Fissell, *Patients, Power, and the Poor*, p.197. Fissell writes, `As Michel Foucault has shown, institutions like prisons, hospitals, and asylums are, on one level, about work discipline. Thus, for example, lines of filiation can be drawn from the two workhouses in Bristol to the Infirmary. The workhouse, or Mint, was destined to discipline those who would not work, while the Infirmary mended those who could not work'. Including in `work discipline', `making people fit for work' is a device

for associating the Infirmary with the notion of discipline which, in fact, never went outside what was necessary for its therapeutic function. Neither is there any possible relationship between either of the two workhouses and Bristol Infirmary that can be called `filiation'. One of the two workhouses referred to by Fissell was the Quaker workhouse founded in 1694. This establishment was not concerned with work discipline. As Braithwaite, *The Second Period of Quakerism*, p.585, writes, it was for `willing Friends to work in and the aged and feeble to live in'.

3 *Bible*, Authorised Version. This saying of Jesus is quoted by Paul in Acts 20:35.

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